THE EXPERIENCE OF STUDENT NURSES WHILE CARING FOR PATIENTS AT RISK FOR SUICIDE

By

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To the Faculty of Washington State University:

The members of the Committee appointed to examine the dissertation of JENNIFER LYNNE MILLER find it satisfactory and recommend that it be accepted.

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Suicide is a major public health problem worldwide. Evidence suggests that healthcare providers do not consistently screen, assess, and manage individuals at risk for suicide. In order for suicide prevention efforts to be efficacious, healthcare providers must understand suicide risk and protective factors, utilize multifaceted approaches to suicide screening and be comfortable with suicide screening, assessment and risk management. Due to the multiple settings in which they encounter and care for patients, nurses are presented with unique opportunities to screen and intervene with patients at risk for suicide. Higher education institutions can better prepare nurses for these opportunities by emphasizing suicide screening, assessment and risk management in their education programs. The aim of this research project was to generate a comprehensive description about the experiences of student nurses while caring for patients at risk for suicide, using transcendental phenomenology. Fourteen Bachelor of Science in nursing (BSN) students and alumni with clinical experience caring for patients at risk for suicide were recruited from two Universities in Eastern Washington State. Each student was interviewed once. Transcribed interview texts were analyzed using Moustakas’ phenomenological methods. Six themes were
identified: Integrating Theory and Practice, Navigating the RN Role, Seeking to Understand the “Why”, Connecting and Relating as Prerequisites to Effectiveness, Judging vs. Empathizing, Managing Stress and Emotion and Expecting the Unexpected. A composite of the textural and structural experiences was then developed. These findings have implications for nursing education, practice, nursing research as well as healthcare policy, and ultimately can result in more favorable patient health outcomes.
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Dedication

This dissertation is dedicated to my family and to my children Ian, Shane and Shannon Bauman, who inspire me to reach further, to strive harder and to be my best self.
CHAPTER ONE
INTRODUCTION

Phenomenon

The phenomenon of interest for this research was the experience of student nurses while caring for patients at risk for suicide. There is limited literature concerning this phenomenon. Due to the multiple settings in which they encounter and care for patients and their families, nurses play a crucial role in suicide prevention and intervention (Chessner, 2011). These encounters provide tremendous opportunities for nurses to screen, intervene, and prevent suicide. While preparing nursing students to care for suicidal persons is a standard part of nursing curricula, nurses consistently report that they lack competencies in caring for suicidal persons (Scheckel & Nelson, 2014). In nursing education, increased emphasis upon effective suicide assessment and interventions can better prepare nurses for their role in suicide prevention.

Research Question, Purpose and Aims

The purpose of this research proposal was to answer the question: “What is the experience of student nurses while caring for patients at risk for suicide?” In order to meet the objective of this proposal, two specific aims were pursued. Specific Aim 1: Understand the experience of student nurses while caring for patients at risk for suicide. Specific Aim 2: Generate a description of the essence of student nurses’ experiences caring for patients at risk for suicide.
Assumptions and Experiences

My personal philosophy and presuppositions motivate my interest in suicide prevention research. Various thinkers have inspired my epistemological and ontological views of the world. Descartes viewed knowledge acquisition as an edifice which builds upon a foundation of thought (Sedgwick, 2001). Descartes’ views provide a framework for philosophers and scientists in their quest for new knowledge. The metaphor of a building further illustrates this process. While a building is built brick by brick, so is the acquisition of new knowledge. New knowledge builds upon past knowledge. This knowledge creates the opportunities for new inquiries and discoveries to be constructed upon this foundation of thought. This process exemplifies how knowledge acquisition has developed in the area of suicide prevention.

Paradigms are also necessary to guide and structure scientific inquiry. Paradigms become our observation lens and affect our perceptions and interpretation of findings (Rodgers, 2005). Kuhn referred to ‘normal science’ as the process by which scientific work is developed in accordance with an established paradigm. However, if we only follow the blueprint of what we expect to find (i.e. an established paradigm), we limit scientific discovery (“The Philosophy of Science”, 2011). Kuhn defined the process of change from one paradigm to another paradigm as a revolution (Rodgers, 2005). This description of knowledge acquisition, while considered radical at the time, validated philosophers and scientists who dared to “think outside the box” and consider new possibilities.

The traditional paradigm about suicide prevention has been to leave suicide prevention in the hands of mental health care providers. This paradigm has not been effective. Individuals are not being identified and managed properly when they are suicidal, and as a result, people
continue to die from this most preventable form of death. Up to 76% of Americans who die by suicide had contact with their primary care provider in the month prior to their death (Luoma, Martin, & Pearson, 2002). “The old paradigm of suicide ‘as the job of mental health people and other misconceptions’ is blocking the goal of preventing suicides” (C. Holliday, personal communication, 2015). Yet there is a recent ‘paradigmatic revolution’ concerning suicide prevention. The National Strategy for Suicide Prevention emphasizes that everyone has a role in preventing suicide and creating a healthier nation (U.S. Department of Health and Human Services, 2012). In Washington State, legislation passed in 2013 under HB 2315 that requires health professionals to obtain continuing education in suicide assessment, treatment, and management (Washington State Department of Health, 2014).

I am a psychiatric and mental health registered nurse, a licensed mental health counselor and a nurse educator. I have experience as a psychiatric and mental healthcare provider in inpatient, partial hospitalization, outpatient clinic, school and private practice settings. I provide didactic and clinical psychiatric and mental health instruction to pre-licensure baccalaureate nursing students. My encounters with suicidal patients in various care settings and my work with student nurses has left me with the sense that the healthcare system must provide better care for persons who are considering ending their lives.

Several factors suggest that the experience of student nurses while caring for patients at risk for suicide may be a complex and perhaps misunderstood phenomenon. Baccalaureate nursing students I work with routinely express reluctance to conduct screenings with at-risk patients, or may avoid the topic altogether, despite having very recent education on how to screen, assess and manage suicidal patients. Nurses often express fear or reluctance to address
suicide with their patients for various reasons cited in the literature. These reasons include fear of interacting with suicidal persons, or they lack competencies necessary to care for this population (Scheckel & Nelson, 2014). Suicide assessment education has been identified as the key to addressing this fear and reluctance. Yet even after student nurses are educated about the topic, the reluctance and avoidance continue. There is something in the students’ experience that has not been identified or is left unexplained. Exploring the student nurse experience may help educators identify how to improve nursing education related to suicide assessment so that student nurses will routinely incorporate suicide assessments in their everyday interactions with patients. The goal of this research is to better understand or uncover the experience of student nurses while caring for patients at risk for suicide. By understanding the experience, educators can more easily identify and implement instructive interventions to improve student nurses’ ability to conduct suicide risk assessments.

In this proposed research, BSN students and alumni participants previously received evidence-based didactic and clinical instruction surrounding therapeutic communication, suicide risk screening, assessment and management. In addition, these students and alumni have experiential knowledge working with patients at risk for suicide. Knowledge also includes ‘reflective practice’ which is considered in light of a priori knowledge and experience (Carper, 1999). In this research, students and alumni were asked to engage in reflective practice and describe their experiences while caring for persons at risk for suicide.

In conversations around my dissertation research, I receive questions about what I expect to find. I sometimes hear well-intentioned comments such as “Don’t you think that you’ll find that students are uncomfortable with suicide?” or “Don’t you think that students do not feel
prepared to respond when someone is suicidal?” But such well-intentioned comments miss the point of scientific inquiry. I understand that students are uncomfortable with suicide and may not feel prepared to respond, yet that is what I am expecting to find. However, I am looking for what I am not expecting to find, what I might have missed.

Due to my clinical experience, experience with students and personal philosophy, as well as the currently evolving paradigm surrounding suicide prevention, I am compelled to explore the phenomenon of student nurses’ experiences while caring with patients at risk for suicide. Descriptive phenomenology is an appropriate methodology for this dissertation. This research approach seeks to elucidate the lived experiences of humans experiencing psychological, medical, developmental, and socio-cultural phenomenon. Elucidation of these student-patient encounters will provide a description the essence of student nurse experiences while caring for patients at risk for suicide.

In my approach to this research, I believe it is necessary that I reflect upon my biases, philosophies and assumptions, and how these might impact the research project and analysis of findings. Given my ongoing work with nursing students, and desire to teach them more effectively, I recognize that I must better understand the phenomenon of student nurses’ experiences while working with individuals at risk for suicide—beyond my own preconceived beliefs. In order to better understand the phenomenon of the student nurse experience, I approach this research in an open and receptive manner. I am striving to “think outside the box” in my scientific inquiry and to remain open to finding what I may not expect to find.
**Definition of Terms**

During the conduction of research, it is important to utilize appropriate terminology and to define the terms that will be used. Terms used in this research include:

**Epoche’ (bracketing).** A state in which the researcher sets aside experiences and assumptions, to whatever degree possible, in order to assume a fresh perspective of the experiences of participants (Creswell, 2013)

**Essence.** A combination of the textural and structural experiences (Moustakas, 1994)

**Phenomenon.** Observable fact, experience or event of scientific interest, to be explored, phrased, and examined in terms of a single concept or idea (Creswell, 2013)

**Phenomenology.** A philosophy and research method which focuses upon “the subjectivity and relativity of reality, continually pointing out how humans view themselves and the world around them” (Willis, 2007, p. 53).

**Structural description.** How participants experienced the phenomenon of interest, in terms of content, condition or situation

**Suicide.** The act of killing oneself or the intentional act of killing oneself, most often as a result of depression or other mental illness (American Psychological Association, 2015)

**Suicide attempt.** A non-fatal self-directed potentially injurious behavior with any intent to die as a result of the behavior. A suicide attempt may or may not result in injury (CDC, 2015)

**Suicidal ideation.** Thinking about, considering, or planning for suicide (CDC, 2015)

**Suicide risk assessment.** The comprehensive evaluation of an individual for current suicide risk, by use of a standard set of interview questions, in order to accurately determine an
appropriate plan of care for an individual. This process extends beyond screening, and may be ongoing, depending upon the needs of the individual.

**Suicide risk screening.** The initial process of evaluating an individual for current suicide risk, by use of a standard set of interview questions including suicidal ideation, suicide plan, access to the means to carry out a suicide plan, and suicide intent. This screening process should then lead to an appropriate intervention with a plan of care that fits the individual’s level of suicide risk.

**Textural description.** What participants experienced with the phenomenon of interest

**Transcendental.** A condition in which everything is perceived freshly, as if for the first time

**Transcendental phenomenology.** “A scientific study of the appearance of things, of phenomenon just as we see them, and as they appear to us in consciousness” (Moustakas, 1994, p. 49).

These terms will be used throughout this research. The definitions provide a background to the study, explanations of the design, data analysis and descriptive findings.

**Summary**

A gap exists in the literature concerning the experiences of BSN student nurses while caring for patients at risk for suicide. Understanding how students feel about caring for suicidal persons is necessary because this reveals how to better prepare students to care for suicidal persons while they receive training to begin professional nursing practice (Scheckel & Nelson, 2014). Research exploring student nurse experiences during encounters with patients at risk for
suicide may offer valuable data to help understand the essence of these experiences. A greater understanding of the experiences of BSN student nurses while caring for patients at risk for suicide can translate to improvements in suicide prevention education, practice, research, policy and better patient safety outcomes.
CHAPTER TWO
REVIEW OF LITERATURE

Introduction

Suicide is indeed a complex phenomenon, and abundant research has been conducted on this topic. This chapter is not intended to be an exhaustive review of the literature on suicide. This chapter investigates the topic of suicide from various dimensions: historical perspectives and theories, prevalence, risk factors, warning signs and protective factors, suicide prevention measures, healthcare policy legislation, Joint Commission standards, and suicide prevention education. The nursing role in suicide screening, risk assessment and management will also be discussed.

Historical Perspectives

A variety of cultural and historical factors contribute to western societal views concerning suicide. Many early civilizations considered suicide as a means of escaping an unbearable existence (Retterstøl, Mortensen, Sundt, & Ystad, 1998). Early Christian condemnations of suicide may have emerged from the view that suicide was despised, because this was the action of Judas, the betrayer of Jesus. Shakespeare influenced societal views towards suicide, as his works often portray sympathetic, melancholy protagonists that died by their own hand. In the late 19th century Durkheim published Le Suicide (1897), which argued that suicide was not just an individual choice, but that society at large acted as a contributing factor to suicide. Freud later theorized that internalized aggression led to suicidal behavior (Meissner,
1977). Indeed, the development and advancement of the fields of sociology, psychology and psychiatry influenced changing attitudes about suicide. These fields validated the notion that mental or emotional distress and suicide can be influenced by social, neurobiological and medical factors.

**Theories**

There are many theories which address the causes of suicide. This review will focus upon three individuals that have greatly influenced our modern understanding of suicide: Durkheim, Shneidman and Joiner. This review will also discuss other theories and scientific advances that have informed our understanding of suicide.

**Emile Durkheim.** Durkheim was a sociologist and founder of the French school of sociology in the late 19th century. In 1897 he published Le SUICIDE, a ground-breaking work in which he posits that suicide was not solely due to a problem within the individual, but was also related to social factors and a breakdown of the societal collective conscience. His work has since been edited and translated (Durkheim, 1979/1897), and remains one of the most influential historical works on suicide. Durkheim identified four types of suicide (Durkheim, 1979/1897):

**Egoistic.** This is caused by outgrowth of the division of labor and the worship of individualism. Life is intolerable unless some reason for existing is involved, or some purpose for enduring life’s trials. When we have only ourselves, “we cannot avoid the thought that our efforts will end in nothingness, since we ourselves disappear” (Durkheim, 1979/1897, p. 210). This perspective can lead to a sense of despair and hopelessness, increasing the risk for suicide.
**Altruistic.** While excessive individuation leads to suicide, insufficient individuation can lead to suicide as well. Suicide can be a by-product of a strong collective conscience. Some examples Durkheim offers are elderly men that commit suicide when they are frail or in poor health, or those that commit suicide after the death of a loved one (Durkheim, 1979/1897). In these cases, the weight of society and a sense of duty or honor to others can be aggravating factors in suicide. Durkheim includes certain group behaviors in this category, such as those who practice certain religious, spiritual or cultural customs, and those who participate in ‘copycat’ types of suicidal behavior, which is sometimes referred to in the literature as “suicide contagion” behavior (Cheng, Li, Silenzio, & Caine, 2014, p. 2).

**Anomic.** Durkheim explains that this type of suicide is also the result of the division of labor, and problems in the structure of the organic system. Economic crises are seen as an aggravating factor in suicide. Poverty alone is not to blame, as suicide rates can also climb during periods of financial prosperity. Here, Durkheim identifies disturbances to equilibrium and periods requiring serious readjustment as times when the risk for suicide can increase.

**Fatalistic.** Durkheim identifies this type of suicide as an aspect of overpowering social control. In this situation, the individual has given up complete authority to another, or had it taken from them, to the point that the only way out is suicide. Some examples include those subjected to slavery, victims of the Jewish holocaust or chronic abuse survivors.

**Edwin Shneidman.** Shneidman is a pioneer in the study of suicide, and is considered a father of modern suicidology (Leenars, 2010). Shneidman, a clinical psychologist, is one of the cofounders of the Los Angeles Suicide Prevention Center, and is also the founder of the
American Association of Suicidology, the first professional organization devoted to the study of suicide. Shneidman’s work provides significant contributions to our modern understandings of suicidal thinking and behavior. Shneidman identified the psychological pain that contributes to suicidal risk. He coined the term “psychache” to explain the psychological pain of unmet needs, which he describes as:

Psychache is the hurt, anguish or ache that takes hold in the mind. It is intrinsically psychological—the pain of excessively felt shame, guilt, fear, anxiety, loneliness, angst, dread of growing old or dying badly. When psychache occurs, its introspective reality is undeniable. Suicide happens when the psychache is deemed unbearable and death is actively sought to stop the unceasing flow of painful consciousness. Suicide is a tragic drama in the mind.

(Shneidman, 1996, p. 13).

According to Shneidman, the suicides he studied in the U.S. tend to fall into one of five clusters of psychological needs:

- A thwarted sense of love, acceptance, and belonging.
- A fractured sense of control and predictability.
- A wounded self-image and avoidance of shame.
- Damaged key relationships and the grief and mourning that accompany such loss.
- Excessive anger, rage, and hostility (Shneidman, 1996, p. 25).
Shneidman explains that while these general themes often manifest in suicides, each suicide is unique, and should be reviewed and considered in its own context. In 1968, Shneidman developed the *psychological autopsy*, which has since been refined. The psychological autopsy is a postmortem procedure to identify the contributing factors of an individual’s death by suicide or to determine the most likely manner of death when the manner of death cannot be determined by medical or forensic examiners. The psychological autopsy is also used in case-control studies to determine risk factors for suicide (Cavanagh, Carson, Sharpe, & Lawrie, 2003) as well as to understand the phenomenon of suicide clusters. Shneidman’s work offers profound insights into the minds of suicidal individuals and greatly informs modern suicide prevention efforts.

**Thomas Joiner.** Joiner, a clinical psychologist, developed the Interpersonal-Psychological Theory of Suicidal Behavior (Joiner, 2005). This theory proposes that an individual will not die by suicide unless he/she has both the desire to die by suicide and the ability to do so. The theory asserts that when individuals hold two specific psychological states in their minds simultaneously (a) *Perceived high burdensomeness*, which is “The idea that my death will be worth more than my life to family, friends, society, etc.” (Joiner, 2009, p. 5), and (b) *A sense of low belongingness or social alienation*. If individuals hold these two simultaneous psychological states in their minds for a long enough period of time, those individuals may develop the desire for death (Joiner, 2009).

The Interpersonal-Psychological Theory of Suicidal Behavior (Joiner, 2005) recognizes that self-preservation is a powerful instinct and few can overcome it by sheer force of will. According to the theory, those who can overcome the self-preservation instinct demonstrate a
sense of daring and risk in the face of pain, injury, and death. It is believed that these individuals acquire this sense through a process of repeated exposures to painful and provocative events. These painful and provocative events may include previous episodes of self-injurious behavior, “but can also include other experiences, such as repeated accidental injuries; numerous physical fights; and occupations like physicians, dentists and front-line soldiers in which exposure to pain and injury, either directly or vicariously, is common” (Joiner, 2009, p. 3). Joiner’s theory provides additional insight into the experiences and behaviors of those at risk for suicide.

**Neurobiology and Genetics.** Several neurobiological and genetic theories of suicide exist. This review briefly identifies theories prevalent in the current literature. The 5-Hydroxytryptamine (5-HTT) serotonin transporter gene has been the most widely studied with moderate association to major depression and suicide (Lee, et al., 2015), and other genes vary by study. While other neurotransmitters are indirectly involved in depression, evidence suggests that reduced serotonin neurotransmission is a primary factor in major depressive disorder (aan het Rot, Mathew, & Charney, 2009; Mann, et al., 2009).

Serotonin-1A (5-HT1A) receptors, while plentiful and widely distributed, are also expressed on serotonin neurons as autoreceptors. Serotonin autoreceptors play an essential role in regulating the activity of the serotonin system. The over-expression of serotonin autoreceptors is believed to reduce serotonin neurotransmission, which is associated with major depression and suicide (Albert, Le François, & Millar, 2011).

Serotonin-2A (5-HT2A) receptors are implicated in a variety of central physiological functions, including those associated with neuropsychiatric disorders. Epidemiological data
suggests that alteration of 5-HT2A signaling may be associated with depression and suicidal behavior. These receptors may directly or indirectly control neuronal excitability in the majority of networks involved in depression through their interactions with monoaminergic receptors, such as dopamine and norepinephrine, as well as glutamatergic and gamma-aminobutyric acid (GABA) receptor neurotransmission (Poulter, et al. 2008).

The effects of stress play a role in the development of anxiety and major depressive disorders. Exposure to chronic, unpredictable stress can generate depressive-type symptoms and suicidal behavior (Leszczyńska-Rodziewicz, Szczepankiewicz, Pawlak, Dmitrzak-Weglarz, & Hauser, 2013). Evidence suggests that epigenetic mechanisms may be involved in the reprogramming of gene expression in response to stressful stimuli (Poulter, et al., 2008). Chronic stress has been shown to negatively affect neurogenesis in the hippocampus, a phenomenon which affects future stress responses (Mahar, Bambico, Mechawar, & Nobrega, 2014). The biological response to stress also involves the hypothalamic-pituitary-adrenal axis (HPA). This axis regulates cortisol levels in the body, arguably the most well-known stress hormone, and dysfunction of the HPA axis has been identified in the pathophysiology of depression and suicide (Pandey, Rizavi, Ren, Dwivedi, & Palkovits, 2013). In their care of patients, it is essential that nurses consider the potential role that genetics, epigenetics, and stress play in the development of patient anxiety responses, depressive symptoms, suicidal thinking and behavior.

**Prevalence**

Suicide represents a major international health issue (Neville & Roan, 2013), and is an increasing public health concern in the United States (Centers for Disease Control and
Prevention, 2013). In the U.S., suicide is the 10th leading cause of death for all ages (CDC, 2013) and the 3rd leading cause of death among adolescents 15-19 years of age. More than 41,000 people die by suicide each year in the U.S. (CDC, 2013). In 2009, the number of deaths from suicide surpassed the number of deaths from motor vehicle accidents in the United States (Rockett, et al., 2012). This data does not reflect the scope of the problem; for every suicide completed, 25 will attempt suicide (CDC, 2012). The figures and graphs below represent prevalence and demographic data of suicides in the U.S.
Suicide rates vary greatly across the United States. As represented in this map, suicide rates by county are higher in certain regions in the west and northwest.

Figure 1. Age-adjusted Suicide Rates per 100,000 Population, by County, in the United States, between 2000–2006 (CDC, 2014).

From 2000–2006 the western U.S. counties, including the states of Montana and Alaska had predominantly high suicide rates. Suicide rates were also high in certain Appalachian counties of Kentucky and West Virginia, southern Oklahoma and northern Florida (CDC, 2014).
In addition to suicide rates per capita, death by suicide can be viewed in relation to other causes of death. This graph reflects 20 leading causes of death by order or frequency.

![Bar chart showing leading causes of death](image)

**Figure 2.** Twenty Leading Causes of Death Among Persons Ages 10 Years and Older, by number in the United States, 2009.

Since 2009, suicide has ranked as the 10th leading cause of death among persons ages 10 years and older, while heart disease, malignant neoplasms and chronic respiratory disease were the top three causes of death among persons ages 10 years and older (2014).
In regards to suicide prevalence, it is important to recognize variances in suicidal behavior between sexes. The completed suicide rate for males ten years and older is approximately four to five-fold the completed suicide rate for females (CDC, 2013).

Figure 3. Trends in Suicide Rates per 100,000 Population among Males, by Age Group, in the United States, 1991–2009 (CDC, 2014).

Since 2005, the suicide rate for males age 10-24 and for males age 65 and older has held relatively constant. Since 2005, the suicide rate for males age 24-64 the suicide rate has increased.
While the rate of suicide completions in males is higher than the rate of suicide completions in females, the rate of suicide attempts among females is higher than the rate of suicide attempt for males (CDC, 2013).

![Trends in Suicide Rates per 100,000 among Females, by Age Group, in the United States, 1991–2009](image)

*Figure 4. Trends in Suicide Rates per 100,000 among Females, by Age Group, in the United States, 1991–2009 (CDC, 2014).*

Since 2005, the suicide rate for females age 10-24 while variable has held relatively constant, as in females age 65 and older. Since 2005, the suicide rate for females age 24-64 has increased.
In order to appreciate suicide risk, it is also necessary to identify the mechanisms that are used in suicide attempts and in suicide completions.

*Figure 5.* Suicides among Persons Ages 10 Years and Older, by Sex and Mechanism, in the United States (CDC, 2014).

As reflected in this graph, the greatest percentage of suicides among males occurred by firearms (56.3%). The greatest percentage of suicides among females occurred by poisoning (39.3%), (CDC, 2014).
Suicide carries significant social and financial impacts, and results in an estimated $34.6 billion in combined medical and work loss costs in the U.S. (CDC, 2013). As evidenced by the suicide rate in the United States and changing demographic of those at risk for suicide, we are not effectively prioritizing and addressing the healthcare crisis that is suicide.

**Risk Factors**

The American Association of Suicidology (2013) identifies various risk factors for suicide that include demographic, historical, psychological and social factors. Risk factors are characteristics that increase the likelihood of suicidal behaviors. While risk factors are not predictors or causes of suicide for any given individual, an individual’s risk for suicide typically increases as personal risk factors accumulate. Historical factors include medical illness, psychiatric illness or family histories that increase patient suicide risk over one’s lifetime. Various psychological and social factors may increase or decrease patient suicide risk. These factors are listed in Table 1.
### Table 1

**Demographic, Historical and Additional Risk Factors for Suicide**

**Demographic Risk Factors:**
- White
- American Indian
- Male
- Older Age
- Separation or Divorce
- Early Widowhood

**Historical Risk Factors:**
- Major Psychiatric Disorders (e.g. depression, anxiety, psychosis, mood disorders)
- Personality Disorders (cluster B traits)
- Medical Disorders that are terminal, involve functional impairment and/or chronic pain
- Recent or Past Psychiatric Hospitalization
- Suicide Ideation or Attempts
- Victim of Trauma or Abuse
- Family History of Suicidal Behavior

**Psychological and Social Risk Factors:**
- Recent Stress or Crisis
- Relational, Social, Work or Family Loss
- Acute or Enduring Unemployment or Housing Loss
- Tolerant/Accepting Attitude Toward Suicide
- Impulsive/Reckless/Aggressive Tendencies
- Victim of Bullying/Humiliation
- Self-Harm Behavior
- Sudden Changes in Behavior, Mood or Somatic Complaints
- Tendency Towards Perfectionism (if accompanied by depression)
- Low Self Esteem/Self-Loathing
- Social Isolation/Lack of Social Support
- Access to Lethal Methods (e.g. firearms, pills)

(American Association of Suicidology, 2013).

For individuals that completed suicide, 90% had a diagnosable mental illness at the time of their death (Chessner, 2011). While suicidal thoughts and behaviors are often associated with psychiatric patients and settings, this is not always the case. Some cases of suicide list no symptoms of mental disorder at the time of death. Epidemiological studies suggest that a variety
of medical illnesses are also associated with suicide (Cho, et al., 2013). Law, Wong & Yip (2015) found that individuals without diagnosed psychiatric disorders displayed fewer warning signs of suicide, yet they experienced more negative life events than living controls. They found that suicide cases without diagnosed psychiatric illness also seemed to be less protected by supportive factors than living controls with and without psychiatric disorders, and used fewer resources than the control and deceased-with-diagnosis groups. “With fewer at-risk signs and less use of resources, these individuals were undetected or unengaged by the existing physical, psychiatric, and psychosocial services” (Law, Wong & Yip, 2015, p. 65).

A significant risk factor for suicide is thoughts of suicide or ‘suicidal ideation’. An individual may have thoughts of suicide, with or without a plan to attempt suicide. If an individual has thoughts and a plan, the individual is at higher risk for suicide. The more detailed, specific and lethal the individual’s suicide plan, the higher their risk for suicide.

The strongest risk factor for predicting suicide and suicide-related behavior is a history of suicide attempts (American Psychiatric Association, 2011). Clinicians must screen for a history of suicidal behavior, and also anticipate times when patients may be vulnerable to suicide (Quinnett, 2000). Specific events can place someone at greater risk for suicide, such as upon psychiatric hospital admission and near discharge, on the anniversary date of tragedy or loss, on holidays, and in times of crisis or perceived loss. The presence of suicide risk factors is associated with increased risk of suicide, and always warrants further scrutiny and inquiry by the RN.

Substance use is also a significant independent risk factor for suicide. In a patient with co-occurring psychiatric and substance abuse disorders, the risk for suicide is even higher.
Consider how substance use affects judgment, impulse control, inhibition, and decision-making skills. “Suicide ideation and alcohol or substance abuse/dependence…are, along with depression, the most consistent predictors for initial nonfatal attempt and suicide” (Beghi, Rosenbaum, Cerri, & Cornaggia, 2013, p. 1725). Patients with co-occurring substance use and psychiatric disorders must be regularly screened for suicide risk.

**Warning Signs**

While factors can place individuals at risk for suicide, warning signs can also signal that an individual is at risk for suicide. Individuals may make hopeless/helpless statements such as “Life is too hard”, “I can’t do this anymore”, “I wish I weren’t here”, “I wish I could sleep forever”, “Everyone would be better off without me”, and so forth. When individuals make such statements, clinicians must inquire further about thoughts of suicide.

A study of the prevalence of suicidal ideation and other suicide warning signs in veterans attending an urgent care psychiatric clinic revealed the following: 52% reported suicidal ideation during the prior week, 37% had active suicidal ideation, 27% of these participants had a current suicide plan, and 12% made preparations to carry out their plan. Other warning signs were prevalent, with the most common being: sleep disturbances (89%), anxiety (76%), agitation (75%), hopelessness (70%), and desperation (70%), (McClure, et al., 2014). This study suggests that an individual’s changes in behavior, sleep and mood may indicate an increased risk for suicide.

Many individuals experience a period of ambivalence before making the decision to act upon suicidal thoughts and impulses. Within the therapeutic context, this ambivalence towards
suicide can be used productively to help patients rediscover meaning and hope. How individuals resolve this ambivalence is key. A sudden, unexplained burst of energy and lifting of mood within the individual may be interpreted by others that the individual is doing better. However, this increased energy and mood lift may indicate that the individual has resolved their ambivalence towards suicide, thus they may be at increased risk for suicide. Additional behaviors may indicate that an individual has resolved this ambivalence towards suicide and is making preparations to carry out their suicide plan. Such behavioral signs may include: giving away belongings, offering farewells, cancelling appointments, settling affairs, making preparations for suicide, and so forth. It is essential that clinicians understand the various warning signs of suicide, and how to effectively identify and intervene when someone is at risk for suicide.

**Protective Factors**

While there are risk factors and warning signs for suicide, these are also areas in an individual’s life that can mitigate or reduce the likelihood of committing suicide. Access to mental health and substance abuse treatment can greatly reduce the risk of suicide. Individual strengths and enhanced coping and problem solving skills can reduce the risk of suicide. A sense of hope, faith and a spiritual belief system can reduce the risk of suicide. An individual’s supportive networks and role responsibilities such as to children or pets can also reduce the risk of suicide. A felt need to ‘be there’ and not abandon those relying upon them can serve as a protective function. Furthermore, an individual’s ability to maintain a cognitive set regarding
“reasons for living” appears to function as a significant protective factor against suicide (American Psychiatric Association, 2011).

**Prevention and Intervention**

An important aspect of suicide prevention is the early recognition of suicide risk and the implementation of preventive measures by health care professionals (Chan, Chien, & Tso, 2009). Successful suicide prevention efforts require a variety of strategies and resources, some which are described.

**Screening.** Those at risk for suicide are not consistently screened and identified by healthcare providers. The majority of suicidal patients motivated by physical illnesses contacted medical care within 1 year prior to suicide, yet many did not receive a psychiatric evaluation (Cho, et al., 2013). Other studies have found that most patients visited their primary care provider within three weeks prior to attempting suicide (Chessner, 2011). These patients expressed a variety of physical and somatic symptoms, yet they rarely directly shared suicidal thoughts or plans with their primary care provider (Chessner, 2011) and were not properly screened and identified. These findings underscore the need for healthcare providers to offer suicide risk screening, assessment and psychosocial support to patients with psychiatric symptoms, somatic complaints or physical illnesses.

Effective suicide screening requires a multifaceted approach in a variety of healthcare settings, targets mental disorders, somatic disorders, indicators of social support, and understanding of demographic, historical, psychological and social risk factors (Crump, et al.,
Suicide prevention efforts that promote identification of suicidal patients should be accompanied by similar efforts to improve suicide risk assessment and management skills, and increase access to mental health specialists (Betz, et al., 2013).

**Risk Assessment and Management.** Horowitz, et al. (2013) found that lack of proper ‘assessment’ was the leading root cause for 80% of all hospital suicides. It is important to train healthcare providers to not just recognize suicide warning signs, but also how to specifically respond to individuals at risk for suicide (Rudd, Goulding, & Carlisle, 2013). The suicide prevention programs that will be discussed in this research are the ASIST and QPR trainings.

**Question, Persuade and Refer (QPR).** The QPR Institute launched as a national suicide prevention training program in 1999. QPR is a structured question and response format-type training used to help individuals learn to effectively identify, communicate with, and refer to appropriate care those at risk for suicide. The Institute offers a variety of training courses which include:

- **QPR Gatekeeper Training.** This fundamental course takes approximately one hour to complete, and is offered through either in-class and online formats.

- **Level 2 QPR Suicide Triage Training.** This course is for crisis volunteers and professionals, clergy members, school counselors, case managers, health care workers or others likely to come into first contact with someone who may be suicidal. This course meets requirements for Washington State law for healthcare professionals, can be completed in six to ten hours, and is offered online.
Level 3 QPRT Suicide Risk Assessment and Risk Management Pro. This interactive course is for professionals responsible for the care and safety of consumers at elevated risk for suicidal behaviors in all settings and across the age span. This course meets requirements for Washington State law for healthcare professionals, can be completed in eight to twelve hours, and is offered online.

QPR for Nurses. This training program targets patient safety, teaches a suicide screening tool, a best practice rapid assessment protocol, updates emerging practice standards, and interventions to prevent veteran suicide. This course can be completed in six hours, and is offered online.

QPR for Physicians, Physician Assistants and Nurse Practitioners. This training program targets patient safety, teaches a suicide screening tool, a best practice rapid assessment protocol, updates emerging practice standards, and interventions to prevent veteran suicide. The course addresses suicide among physicians. This course can be completed in six hours and is offered online.

The QPR Institute offers additional courses for EMS and firefighters, correctional and law enforcement personnel, and instructor certification programs (QPR Institute, 2015).

Applied Suicide Intervention Skills Training (ASIST). ASIST training was developed in 1983, and is used around the world. The goal of ASIST training is to build comfort and understanding around suicide and suicide intervention. The ASIST workshop is divided into five sections: Preparing, Connecting, Understanding, Assisting, and Networking. ASIST training is available to the general public and to healthcare professionals (LivingWorks Education, 2014).
The ASIST and QPR training programs have demonstrated reliability and validity in the literature. In a study of the National Suicide Prevention Lifeline's national network of crisis hotlines, callers were found to feel significantly less depressed, less suicidal, less overwhelmed, and more hopeful by the conclusion of calls handled by ASIST-trained counselors as compared with counselors that did not receive the ASIST training (Gould, Cross, Pisani, Munfakh, & Kleinman, 2013). Following QPR gatekeeper training, participants demonstrated significant increases in knowledge of suicide and perceived efficacy towards helping someone at risk for suicide (Cerel, Padgett, Robbins, & Kaminer, 2012). Participants that received ASIST or QPR gatekeeper training have been found to demonstrate greater knowledge and skill related to suicidal behavior as compared with participants that did not receive the gatekeeper training (Smith, Silva, Covington, & Joiner, 2014).

It is important that suicide prevention training programs are efficacious and supported by the literature. The quality of training program is particularly relevant to nurses and other healthcare providers that pursue suicide prevention training as a means to maintain professional competence or to meet continuing education requirements for professional licensure.

**Health Policy and Legislation**

The Surgeon General of the United States released a *Call to Action to Prevent Suicide* (1999), declaring suicide a national public health issue. Later, the Department of Health & Human Services first published the *National Strategy for Suicide Prevention: Goals and Objectives for Action* (2001), which challenged states to take action in order to reduce suicide rates. The New Freedom Commission on Mental Health released a report titled *Achieving the Promise: Transforming Mental Health Care in America* (2002), which supports the *National Strategy for Suicide Prevention*.

In 2012, the U.S. Surgeon General, in partnership with the National Action Alliance for Suicide Prevention, put forth the 2012 National Strategy for Suicide Prevention: Goals and Objectives for Action. This national strategy put forth four Strategic Directions: (1) Healthy and Empowered Individuals, Families, and Communities, (2) Clinical and Community Preventive Services, (3) Treatment and Support Services, and (4) Surveillance, Research, and Evaluation (United States Department of Health and Human Services, 2012). Indeed, various developments have influenced shifting societal attitudes about suicide, and resulted in changes to legislation concerning suicide.

**Zero Suicide Movement.** The Zero Suicide movement is a public-private partnership advancing the National Strategy for Suicide Prevention. This movement develops from the U.S. Air Force suicide prevention efforts in the 1990’s, but is primarily based upon work done in a variety of health care organizations, particularly the Henry Ford Health System (HFHS). Zero Suicide is a commitment to suicide prevention in health and behavioral health care systems. The core proposition of Zero Suicide is that suicide deaths for people under care are preventable and
that the goal of zero suicides among persons receiving care is an aspirational challenge that health systems should accept. The Zero Suicide approach aims to improve care and outcomes for individuals at risk of suicide in health care systems, and also offers specific tools and strategies. Zero Suicide represents a commitment to patient safety and to the safety and support of clinical staff who treat and support suicidal patients (Reed, 2013; Suicide Prevention Resource Center, 2015).

**Legislation.** Effective June 12, 2014, legislation passed under HB 2315 in Washington State that requires healthcare professionals to obtain continuing education (CE) in suicide assessment, treatment, and management. Registered Nurses are included in this CE requirement. This bill requires disciplinary authorities such as professional Commissions to adopt rules to implement this legislation. The disciplining authority (Commission) may approve only screening and referral elements if appropriate for the profession in question, and based upon the profession's scope of practice (Washington State Department of Health, 2014). Suicide assessment, treatment and management are a necessary skillsets for nurses and other healthcare professionals.

**Joint Commission Standards**

Since 1995, suicide has ranked in the top five most frequently reported events to The Joint Commission (Joint Commission, 2010). The Joint Commission adopted a formal Sentinel Event Policy in 1996 to help hospitals that experience serious adverse events learn from those events and improve safety. Careful investigation and root cause analysis of Patient Safety Events and evaluation of corrective actions is necessary to reduce risk and prevent patient harm (2015).
The Joint Commission has identified suicide prevention as a 2015 National Patient Safety Goal to assure that patients within hospital units and in residential treatment settings at risk for suicide are appropriately screened and cared for (Joint Commission, 2015).

Figure 6. 2015 Joint Commission National Patient Safety Goals

Challenges and Barriers

In clinical practice, nursing students may demonstrate reluctance to conduct suicide screening, assessment, and risk management with high risk patients, or may avoid the topic altogether. Student nurse reluctance or avoidance to conduct screening, assessment, and risk management with high risk patients has been observed to occur even after students have received exposure to a variety of didactic and clinical instructional materials and activities, and have
earned satisfactory test scores on suicide-related content. These instructional materials include: verbal, written and multimedia education regarding suicide statistics and facts, suicide myths, structured suicide screening tools and evidence-based practice guidelines, suicide assessment and risk management technique demonstrations, and practice during classroom suicide screening, assessment, and risk management role play activities.

Healthcare providers’ reluctance, ambivalence or avoidance of approaching the topic of suicide is not leading to favorable patient health outcomes. As evidence suggests, those at risk for suicide are not consistently screened, identified and treated. Healthcare provider’s limited knowledge of acute and chronic suicide risk factors, warning signs, as well as negative attitudes towards patient suicidal behavior have been found to interfere with proper screening and identification of suicidal patients (Botega, et. al, 2005). Suicide prevention efforts that promote better identification of suicidal patients should be accompanied by similar efforts to improve suicide risk assessment and management skills and increase access to mental health specialists (Betz, et al., 2013).

The Nursing Role

Due to the multiple settings in which they encounter and care for patients, nurses play a crucial role in suicide prevention at every level (Chessner, 2011). Suicide prevention is influenced by nurses' ability to accurately screen, assess, and manage a patient's suicide risk (Neville & Roan, 2013). Effective suicide screening, risk assessment and management require a multifaceted approach in a variety of healthcare settings, and targets mental disorders, somatic disorders and indicators of social support (Crump, et al., 2013). Effective suicide prevention
strategies require a comprehensive understanding of demographic, historical, psychological and social risk factors, and greater understanding of barriers to suicide risk assessment and management.

Nursing students face difficult work as they learn to develop professional boundaries and new ways to and communicate and relate with others (Benner, Sutphen, Leonard, & Day, 2010). Navigating this role transition can prove challenging for the novice nurse. In nursing education, increasing emphasis upon suicide screening, risk assessment and management can prepare nurses for their future role in suicide prevention.

Prevention Education

The formation and development of clinical and emotional skills are essential for care delivery to patients with suicidal ideation or behavior (Carmona-Navarro & Pichardo-Martínez, 2012). Possessing a higher degree of mental health training and a high level of emotional intelligence is associated with a more positive attitude towards patients with suicidal behavior (Carmona-Navarro & Pichardo-Martínez, 2012). Complex attitudes need to be considered in professional healthcare training and in the development of contemporary suicide prevention policy (Anderson & Standen, 2007). Because attitudes influence the effectiveness of health care personnel interventions, research findings may have important implications for the development of suicide prevention education programs (Botega, et. al, 2007). This education should not be based solely be knowledge acquisition, but also upon changing attitudes towards patients at risk for suicide (Botega, et. al, 2005).
Summary

It is essential to grasp the extant literature on the topic of suicide in order to approach the research in an informed manner. This chapter reviewed the literature on suicide in a variety of areas. A gap exists in the literature concerning challenges and barriers to suicide screening, risk assessment and management amongst nurses and in particular, student nurses. Furthermore, the current literature does not sufficiently address the challenges facing healthcare providers when asking the hard questions about suicide and suicidal behaviors of their patients. Understanding and addressing these barriers and challenges can lead to more effective suicide prevention efforts in healthcare settings.
CHAPTER THREE
RESEARCH DESIGN AND METHOD

Methodology

This study proposed the use of a qualitative research design and phenomenological research method in order to study the complex human experience of caring for suicidal patients. In research, theoretical underpinnings help inform and explain research findings and guide the researcher. This study was not hypothesis driven. This study used a qualitative, descriptive methodology based upon phenomenology. In phenomenology, the researcher’s goal is to “neither add nor subtract” (Giorgi, 2009, p. 89) from what is experienced, and everything is to be regarded from the participant's "perspective of consciousness" (Giorgi, 2009, p. 87). In order to uncover the essence of the experience of student nurses while caring for patients at risk for suicide, the researcher must remain open to students’ subjective experiences with this phenomenon. The phenomenological method and systematic procedures are consistent with my own philosophical views. These views include incorporating objective and subjective approaches to data collection, and detailed, rigorous steps of data analysis.

A post-positivistic, empirical scientific method cannot thoroughly answer all research questions (Holliday, 2012). Some research questions require a different method of inquiry in order to advance understanding of complex human phenomena. As stated by Giorgi, “If one asks a quantitative question, then one should use a quantitative method; if one asks a qualitative question, then one should use a qualitative method” (2009, p. 5).
Qualitative research seeks to describe the complex nature of humans and how individuals perceive their own experiences within a specific social context. Qualitative research uses the subject’s own words and narrative summaries of observable behavior to express data rather than numerical data derived from predetermined rating systems. The qualitative approach emphasizes an understanding of human experience, exploring the nature of people’s transactions with themselves, others and their surroundings. Qualitative designs and methods also allow the study of many simultaneous variables contained in a phenomenon.

(Portney & Watkins, 2009, p. 306)

Phenomenology as a research method explores the meaning of experiences and can help advance our understanding of phenomena. Phenomenological research methods assist nurses to develop a fresh, unbiased lens through which to explore phenomena of interest to nursing (McNamara, 2005). For these reasons, descriptive phenomenology was chosen to answer the research question, “What is the experience of student nurses while caring for patients at risk for suicide?”

It is necessary to understand and appreciate the philosophical foundations of a method in order to rigorously apply the method to research (Holliday, 2012). For this reason, a brief description of the historical and philosophical background of phenomenology will be provided. Then, an introduction to Moustakas’ research method and how descriptive phenomenology applies to the research question will be explained. Moustakas’ method is ideal for novice researchers (Creswell, 2013), and is the method chosen for this research.
Phenomenology as a Philosophy

The word phenomenology is derived from the Greek words *phantaménōn* meaning appearance, and *logos* meaning reason (Walters, 1995). The roots of phenomenology as a philosophy lie in ancient Greek thought and humanistic traditions. Descartes’ contributions to ontology and epistemology provided a foundation for the development of modern phenomenological philosophy. Descartes held to a “skeptical method” which doubts knowledge that can only be known through the senses. Instead, Descartes placed the “self” and “cogito” (‘I think’) at the center of his view of epistemology (Sedgwick, 2001). He distinguished humans as capable of rational thought and introspection, able to reflect upon their thoughts and ideas through reason. Descartes is credited with identifying “ideas” as a focus of thought and the concept of mind-body dualism, which remain some of his greatest contributions towards philosophy and epistemology (Rodgers, 2005).

Franz Brentano (1838–1917) is considered a forerunner of the phenomenological movement (Huemer, 2014). According to Brentano, all mental phenomena are conscious and must be studied from the first person perspective, a method he called ‘phenomenology’ (Bayne & Montague, 2011). “Every idea or presentation which we acquire through sense perception or imagination is an example of a mental phenomenon… furthermore every judgment, every recollection, every expectation, every inference, every conviction or opinion, every doubt is a mental phenomenon” (Brentano, 1874, p. 78-79).

While there are many versions of phenomenological philosophy, this approach is largely based upon the writings of mathematician Edmund Husserl (1859-1938) and others who expanded on his work, namely Heidegger, Sartre and Merleau-Ponty (Creswell, 2013). Husserl
was greatly influenced by Descartes (Moustakas, 1995), and is considered one of the most influential philosophers of the 20th century (Phillips-Pula, Strunk, & Pickler, 2011). Husserl is credited with developing phenomenology as a philosophical method of measuring human consciousness. Husserl explained that since humans have the capacity for consciousness, they are fundamentally different from nature and physical matter, thus understanding human experience requires research methods other than those developed for the physical sciences (Sawicki, n.d.).

**Phenomenology as a Research Method**

Phenomenology is a trans-disciplinary movement and developed both as a philosophy and a research method. The phenomenological research approach is often utilized in the social and health sciences, such as sociology, psychology, nursing and education (Creswell, 2013). In psychology, the term phenomenology is generally used to describe any theory, practice, or research in which the first-person account is the focus (Wertz et al., 2011). In research, “phenomenology is the study of structures of consciousness as experienced from the first-person point of view” (Smith, 2013). The aim of phenomenology is to understand the essential structure of an experience, as experienced by the subject (Seaton, 2005). Those who engage in phenomenological research focus upon the participants’ subjective experience with the phenomenon and what participants have in common as they experience a phenomenon (Creswell, 2013). Knowing and understanding common experiences can be valuable and instructive for many groups, including therapists, educators, healthcare personnel and policymakers (Creswell, 2013). In the health sciences, the phenomenological approach to
research offers implications for healthcare reform, patient teaching, patient-provider communication, patient satisfaction and patient health outcomes.

**Descriptive vs. Interpretive**

There are two distinct branches of research phenomenology, descriptive and interpretive. The key difference between these two approaches lies in how data is analyzed and the underlying philosophical assumptions of each. Simply stated, interpretive approaches emphasize researcher interpretation of the data, while descriptive approaches emphasize detailed descriptions of the data. In contrast to interpretive phenomenology, descriptive phenomenology is focused less upon interpretations of the researcher, and more upon the experiences of the participants.

Descriptive phenomenology is referred to in the literature as empirical, transcendental, or psychological phenomenology. Giorgi (2009) has played a leading role in adapting and developing systematic descriptive phenomenological methods for empirically based psychological research (Wertz et al., 2011). Others have drawn from Giorgi’s work, including Moustakas (1994) who developed transcendental phenomenology as a structured approach to data analysis. Descriptive transcendental phenomenology is the methodology chosen for this research because this approach best answers the research question: What are the experiences of student nurses while caring for patients at risk for suicide?
Assumptions and Definitions

The application of phenomenology in research requires understanding of the broader philosophical assumptions, ideas, and concepts of this methodology (Creswell, 2013). Key definitions and assumptions of transcendental phenomenology are provided.

**Epoche** (bracketing). Epoche is a Greek word meaning to refrain from judgment, to abstain from the everyday, ordinary way of perceiving things. Epoche is a necessary first step whereby the researcher sets aside preconceived understandings and judgments, and approaches phenomena in a fresh, open manner (Moustakas, 1994). In this state, researchers must assume a transcendental phenomenological attitude, where everything is regarded from the participant's "perspective of consciousness" (Giorgi, 2009, p. 87). A strategy that can assist the researcher to achieve epoche is the use of a reflective diary (Wall, Glenn, Mitchinson, & Poole, 2004), which will be explained further.

**Essence.** Essence is defined as the essential invariant structure or the central underlying meaning of the experience (Creswell, 2013). Descriptive phenomenologists ask the questions: What are the individual’s experiences, and in what context did they experience them? This approach focuses on discovering the wholeness of the experience and revealing its essence, or truth (Moustakas, 1994).

**Imaginative Variation.** Imaginative variation follows and is defined as the “acceptance of descriptions of the experience exactly as related by study participants” (Phillips-Pula, Strunk, & Pickler, 2011, p. 67). “Its aim is to grasp the structural essences of experiences… from this process a structural description of the essences is derived, presenting a picture of the conditions that precipitate an experience and connect with it” (Moustakas, 1994, p. 35).
**Intentionality.** Intentional experiences are acts of consciousness. Researchers examine what arises first and foremost as a synonym for consciousness itself. Intentionality directs consciousness towards the phenomena of interest (Moustakas, 1994). Researchers emphasize the intentionality of consciousness where experiences contain both the outward appearance and inward consciousness based on memory, image and meaning. This intentionality helps to elucidate the essence of an experience (Creswell, 2013).

**Transcendental Phenomenological Reduction.** The descriptive phenomenological method of analysis uses language as data and is inductive in nature. In this step, transcripts will be analyzed by the researcher and dissertation chair. During the Transcendental Phenomenological Reduction, each experience is considered in its singularity, in and for itself. The phenomenon is considered in its totality, in a fresh and open way. A complete description is given of its essential constituents, variations of thoughts, feelings, and each element of the experience (Moustakas, 1994). The purpose of this methodology is to identify and describe how human phenomenon are meaningfully experienced, and to "neither add nor subtract" (Giorgi, 2009, p. 89) from what is experienced. Ultimately, the researcher derives “a textural description of the meanings and essences of the phenomenon, the constituents that comprise the experience in consciousness, from the vantage point of an open self” (Moustakas, 1994, p. 34).

These philosophical assumptions and definitions were applied throughout all phases of this research. In addition, specific procedural steps of transcendental phenomenology were followed.
Procedures

Transcendental phenomenology as a human science research method involves several procedural steps, as described below in Table 1.

<table>
<thead>
<tr>
<th>Table 2</th>
<th>Transcendental Phenomenology Procedures</th>
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<tbody>
<tr>
<td>1.</td>
<td>Discovering a topic and question rooted in autobiographical meanings and values, as well as involving social meanings and significance;</td>
</tr>
<tr>
<td>2.</td>
<td>Conducting a comprehensive review of the professional and research literature;</td>
</tr>
<tr>
<td>3.</td>
<td>Constructing a set of criteria to locate appropriate co-researchers;</td>
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<tr>
<td>4.</td>
<td>Providing co-researchers with instructions on the nature and purpose of the investigation, and developing an agreement that includes obtaining informed consent, insuring confidentiality, and delineating the responsibilities of the primary researcher and participant, consistent with the ethical principles of ethical research;</td>
</tr>
<tr>
<td>5.</td>
<td>Developing a set of questions or topics to guide the interview process;</td>
</tr>
<tr>
<td>6.</td>
<td>Conducting and recording a lengthy person-to-person interview that focuses upon bracketing the topic and question;</td>
</tr>
<tr>
<td>7.</td>
<td>Organizing and analyzing the data to facilitate development of individual textural and structural descriptions, and a synthesis of textural and structural meanings and essences.</td>
</tr>
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(Moustakas, 1994, p. 103-104).

Design

This study proposed the use of a qualitative, cross-sectional research design, face-to-face interviews, and a transcendental phenomenological research method to answer the research question, “What is the experience of student nurses caring for patients at risk for suicide?” A human science research question has definite characteristics:

1. _It seeks to reveal more fully the essences and meanings of human experience_;

2. _It seeks to uncover the qualitative rather than the quantitative factors in behavior and experience_;
3. *It engages the total self of the research participant, and sustains personal and passionate involvement;*

4. *It does not seek to predict or to determine causal relationships;*

5. *It is illuminated through careful, comprehensive descriptions, vivid and accurate renderings of the experience, rather than measurements, ratings, or scores.*

   (Moustakas, 1994, p. 105)

Single interviews were conducted to collect narrative data from recent BSN alumni. Descriptive phenomenology was chosen as the method to solicit the experiences of student nurses while caring for patients at risk for suicide.

**Sample and Sampling Plan**

Research participants were identified through the use of purposeful or snowball sampling. Over a three month time period, 15 adult participants at least 18 years or older were recruited after completion of their BSN education. In transcendental phenomenological research, Moustakas recommends a sample size of 12 to 15 participants (Moustakas, 1994). In this study, 15 participants were recruited and interviewed in order to assure an adequate sample size. The Washington State University College of Nursing BSN and Gonzaga University pre-RN licensure programs were specifically targeted for recruitment. Pre- and post-licensure graduates were recruited because they received didactic and clinical instruction pertaining to psychiatric and mental healthcare, and these experiences increased the likelihood of their exposure to patients at risk for suicide.
During the recruitment procedures, the project was identified as doctoral student research. The researcher recruited students to be interviewed about their experiences working with patients at risk for suicide. Students were recruited via classroom visits, campus flyers and campus emails. Recruitment flyers were placed on campus bulletin boards and in student lounge areas within the College of Nursing. Students were also recruited through WSU campus email. Approval was sought by the Washington State University and Gonzaga University IRBs for all methods of recruitment. Recruitment continued for a period of three months, or until 15 participants were identified. Students were offered $20 cash as incentive for their participation in this research.

The purposeful sampling method applied the following inclusion criteria: adult pre- or post-licensure recent BSN alumni, 18 years of age or older, English speaking, male and female, all ethnic and racial groups, received didactic and clinical instruction related to psychiatric and mental healthcare, and have clinical experience with patient(s) at risk for suicide. Students with a prior earned degree in a mental health related field and students that were experiencing current suicidal thoughts or feelings were excluded from the study.

Data Collection

In phenomenological investigation the long interview is the typical method through which data is collected on the research question (Moustakas, 1994). Data collection was conducted through single, in-depth, in-person interviews with 15 participants. Pseudonyms were used to protect the identities of the participants.
The phenomenological interview involves an informal, interactive process and utilizes open-ended comments and questions…Often the phenomenological interview begins with a social conversation or a brief meditative activity aimed at creating a relaxed and trusting atmosphere. Following this opening, the investigator suggests that the (participant) take a few moments to focus on the experience, moments of particular awareness and impact, and then to describe the experience fully. The interviewer is responsible for creating a climate in which the research participant will feel comfortable and will respond honestly and comprehensively (Moustakas, 1994, p. 114).

During the interview, the focus was upon gathering data which lead to textural and structural descriptions which enhanced understanding of participants’ individual and common experiences. In order to accomplish this, the researcher asked two broad and general questions as interview prompts:

(a) “Please recall and tell me about your experience working with patients at risk for suicide”

(b) “What contexts or situations have influenced or affected your experience?”

Additional open-ended prompts were used to facilitate the interview and are listed in Appendix A. Each interview lasted for approximately 30 to 60 minutes. The interview data was recorded with a digital audio recorder and transcribed into texts by a research-trained transcriptionist.
**Data Analysis**

Phenomenological data analysis steps are similar for all descriptive phenomenological methods, yet in the literature several key methods of descriptive phenomenological analysis are used (Moustakas, 1994). The Moustakas approach to data analysis (Moustakas, 1994) is advantageous for novice researchers, as it helps provide a structured approach to data analysis (Creswell, 2013). The method chosen of organizing and analyzing qualitative data used in this research was the Stevick (1971), Colaizzi (1979), and Keen (1975) method, modified by Moustakas (1994) and further elucidated by Phillips-Pula, Strunk, & Pickler (2011). This method contains the following steps:

1. Record all relevant statements.
2. Read and reread participants’ descriptions of the phenomenon in order to acquire a general sense of the experience.
3. Return to original transcripts and extract significant statements pertaining to the phenomenon.
4. List each non-repetitive, non-overlapping statement. These are the invariant horizons or meaning units of the experience.
5. Relate and cluster the invariant meaning units into themes.
6. Synthesize the invariant meaning units and themes into a *description of the textures of the experience*. Include verbatim examples.
7. Construct a *textural-structural description* of the meanings and essences of the experience.
8. From the verbatim transcripts of the experience of each of the participants, complete the above steps.

9. From the individual textural-structural descriptions of all participants’ experiences, construct a composite textural-structural description of the meanings and essences of the experience, integrating all individual textural-structural descriptions into a universal description of the experiences representing the group as a whole.

10. If new data are revealed during the validation, incorporate changes and reproduce the textural-structural description of the experience.

In keeping with the analysis methods for Transcendental Phenomenology (Moustakas, 1994), the methods above were chosen for organizing and analyzing the data collected in this research.

**Evaluation of Data Validity and Scientific Rigor**

Qualitative researchers sometimes face criticism from quantitative researchers due to perceptions that qualitative research lacks scientific rigor in comparison to quantitative research. While quantitative researchers collect objective and measurable data that can be generalized, qualitative researchers collect subjective data about contextual life experiences (Holliday, 2012). When generalizability to populations is not a primary research goal, it is essential to identify evaluation criteria that can be applied towards qualitative data.

Within the realm of qualitative research, Lincoln and Guba’s seminal work (1985) identified the validity criteria credibility, dependability, confirmability and transferability.
Whittemore, Chase and Mandel (2001) provided a reconceptualization of validity in qualitative research. Their synthesis resulted in the identification of four primary criteria (integrity, authenticity, credibility and criticality) and six secondary criteria (explicitness, vividness, creativity, thoroughness, congruence and sensitivity) for evaluation of qualitative research. Other researchers have attempted to reconceptualize rigor and validity and proposed additional frameworks for evaluation of qualitative research (Cope, 2014; Creswell & Miller, 2000; Morse, Barrett, Mayan, Olson, & Spiers, 2002; Nakkeeran & Zodpey, 2012).

This research applied the standards of validation and evaluation put forth by Polkinghorne (1989) and Creswell (2013), as these standards suit the philosophical framework of this research. Polkinghorne (1989) identifies five questions that researchers may ask themselves.

- Did the interviewer influence the contents of the participants’ descriptions in such a way that the descriptions do not truly reflect the participants’ actual experience?
- Is the transcription accurate, and does it convey the meaning of the oral presentation in the interview?
- In the analysis of the transcriptions, were there conclusions other than those offered by the researcher that could have been derived? Has the researcher identified these alternatives?
- Is it possible to go from the general structural description to the transcriptions and to account for the specific contents and connections in the original examples of the experience?
- Is the structural description specific, or does it hold in general for the experience in other situations? (Polkinghorne, 1989).
Creswell (2013) identifies five standards to assess the quality of phenomenological research.

- Does the author convey an understanding of the philosophical tenets of phenomenology?
- Does the author have a clear “phenomenon” to study that is articulated in a concise way?
- Does the author use procedures of data analysis in phenomenology, such as the procedures recommended by Moustakas (1994)…?
- Does the author convey the overall essence of the experience of the participants? Does the essence include a description of the experience and the context in which it occurred?
- Is the author reflexive throughout the study? (Creswell, 2013, p. 260).

Reflexivity significantly adds to the rigor of qualitative research (Darawsheh, 2014). Reflexivity refers to the continuous self-reflection process qualitative researchers perform in order to generate awareness of their perceptions, thoughts and actions (Hughes, 2014). The approach of the reflexive researcher is questioning and introspection. Reflexivity enables researchers to make conscious personal attributes or assumptions that may influence the research process (Jootun, McGhee, & Marland, 2009). This process allows researchers to ‘set aside’ and control subjectivity so as not to apply their own interpretations on participants’ accounts (Jootun et al., 2009; Smith, 2006). Reflexivity also allows the researcher to provide rationale for research decisions and to guide the research process to generate relevant findings (Smith, 2006).

At each phase of this research, the five questions (Polkinghorne, 1989) and five standards (Creswell, 2013) noted above were considered reflexively in order to assess the quality of this
phenomenological study. Several additional strategies were utilized to ensure data quality and scientific rigor. These strategies include: maintaining field notes, referring back to the transcripts, peer debriefing and maintaining an audit trail (Creswell, 2013).

Transcripts were analyzed once they were received, and guided decisions related to further data collection (Moustakas, 1994). Transcripts were analyzed by two or more analysts. As each transcript was analyzed, any needed clarifications were made through frequent reference back to the text. After each individual textual analysis, the analysts verbally engaged in peer debriefing and reviewed findings with the research team. Saturation is the point in data collection when no new or relevant information emerges with respect to the phenomenon of interest, and the researcher looks at this as the point at which no more data need to be collected (Saumure & Given, 2008). In this study, data saturation was found after analyses of nine transcripts, but continued until all 14 transcripts were analyzed. These procedures were conducted throughout the phases of data analysis.

Human Subjects

This research project was approved by the Washington State University and Gonzaga University Institutional Review Boards. The transcribed data was kept in a password protected computer in the investigator’s private locked office at Gonzaga University in Spokane. The printed transcripts and all products of analysis were kept in a locked file cabinet in the investigator’s private locked office at Gonzaga University in Spokane. The audio tapes will be stored for three years and then will be destroyed. The de-identified transcripts will be kept indefinitely. All electronic files were encrypted as required by Washington State University’s
Office of Research Compliance. Only the investigator and members of her supervisory committee have access to the original interview tape recordings, the transcribed data and electronic files generated during analysis. The consent form contained a second signature line that required the participants to acknowledge that the interview is being audio tape recorded. Informed consent was obtained prior each interview. The participants were told that the information obtained during the interview will be kept confidential unless plans to harm him/herself, plans to harm others or abuse of a child or dependent adult are disclosed. The participants were informed of their right to terminate the interview at any time or for any reason.

**Risks and Benefits**

The potential risks of participating in this study were minimal. However, participants may have experienced mental or emotional distress due to the sensitive nature of the topic of suicide. To address the potential risk of emotional distress, participants were provided the number for the Washington State University Spokane Counseling Services and Gonzaga University Health and Counseling Services on the consent form. The potential benefits of participating in this study included greater insight and understanding of the opportunities and roles of students and nurses in caring for patients at risk for suicide. While the intent of this research is not educational, the researcher recognizes that increased awareness of suicide prevention may develop as a result of participating in the interview. As student nurses reflect on their experience working with patients at risk for suicide, naturally they will think about what could have done differently or what was done well, thus raising their awareness of the role they play in suicide prevention.
CHAPTER FOUR

FINDINGS

Introduction

These findings describe the meaning and essence of the experience of student nurses while caring for patients at risk for suicide, as constructed from Moustakas’ Transcendental Method of phenomenological analysis of the accounts of 14 BSN student nurses. Each student recalled their experience while working with patient(s) at risk for suicide. The participants were asked to respond to the following question prompts:

1. Please recall and tell me about your experience working with patients at risk for suicide.
2. What contexts or situations have influenced or affected your experience?
3. What dimensions, incidents and people intimately connected with the experience stand out for you?
4. How did the experience affect you? What changes do you associate with the experience?
5. How did the experience affect significant others in your life?
6. What feelings were generated by the experience?
7. What thoughts stood out for you?
8. What bodily changes or states were you aware of at the time?
9. Have you shared all that is significant with reference to the experience?

Moustakas, 1994, p. 116
The participants’ responses may be understood as representative voices of BSN student nurses who have had encounters with patients at risk for suicide. Descriptive findings were derived from analyses within and across the verbatim de-identified texts of interviews with these participants. Through the interview process, the student nurses reflected upon and constructed their patient encounters, bringing to the forefront the essence of their experiences. The methodical and iterative review of these texts led to the identification of common themes across descriptions. The findings help clarify the experiences of student nurses while caring for patients at risk for suicide, an essential factor to help educational and healthcare professionals design and implement more effective methods of instruction and training procedures surrounding suicide screening, assessment, and intervention. A description of participants’ accounts and of the essence of these experience are the results that follow.

**Participant Background Information**

The initial participant sample consisted of 15 pre- or post-RN licensure nursing students and alumni who identified themselves according to the following pseudonyms: Rebecca, John, Jackie, Chrissy, Tessa, Rose, Abby, Liz, Maria, Sarah, Sally, Julie, Marie, Jo and Taylor. One research participant shared a personal experience with an acquaintance that was previously suicidal, but did not offer a patient example. This participant’s interview transcript was read and reviewed by the research team, but was not included in this analysis, as the content did not meet the criteria for inclusion into this study. Each of the remaining 14 participants had at least one experience caring for a patient at risk for suicide when they worked within the student nurse role. The participants ranged in age from 22-43 years old. Thirteen out of 14 participants were female.
The participants were recruited and interviewed immediately prior to or within three months of completing their Bachelor of Science in nursing degree. Age, sex and academic institution of degree completion were the demographic information collected.

**Themes**

Fourteen pre- and post- licensure BSN nursing students and alumni recounted their experiences while caring for patients at risk for suicide. Their stories were varied and detailed. In this descriptive analysis, specific meaning units were identified, related and clustered into themes. Six separate themes were identified (see table 3). The meaning units and themes were then synthesized into a *description of the textural-structural experiences*, and verbatim examples were included. From the individual textural-structural descriptions of all participants’ experiences, a *composite textural-structural description of the meanings and essences of the experience* was constructed, while integrating all individual textural-structural descriptions into a universal description of the experiences representing the group as a whole.
Table 3

Themes Identified

<table>
<thead>
<tr>
<th>Theme 1: Integrating Theory and Practice</th>
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<tr>
<td>Theme 2: Navigating the RN Role</td>
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<tr>
<td>Theme 3: Relating to Understand the “Why”</td>
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<td>Theme 4: Judging vs. Empathizing</td>
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<td>Theme 5: Managing Stress and Emotion</td>
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<td>Theme 6: Expecting the Unexpected</td>
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The themes are described below. All of the participants recounted experiences from their BSN, pre-licensure, first person clinical practicum experiences. Students’ experiences with patients at risk for suicide occurred within a variety of healthcare settings, including inpatient and outpatient psychiatric settings, outpatient substance abuse and co-occurring disorder treatment settings, the emergency department, and various inpatient pediatric, medical, surgical and oncology units. Exemplars from the transcribed interviews demonstrate how the themes were derived. The interview data is represented without interpretation. The data is not used to draw inferences about healthcare providers or healthcare episodes, but to describe the student nurse experience surrounding care of suicidal patients. Themes are listed in the order in which the members of the research team identified them within the interview transcripts.

**Theme 1: Integrating Theory and Practice.** *Integrating Theory and Practice* was the primary theme identified in each of the 14 interviews. This theme encompasses the theory-
practice gap (Ward, 2011), combining knowledge and practice within the healthcare setting, and applying policy to healthcare situations. Many students identified theories they learned surrounding proper care for suicidal persons, yet what they encountered in the clinical setting varied greatly from what they had learned. Some of these variations in practice were related to resource availability and access to care issues. Some students shared experiences where the medical or psychiatric needs of patients were overlooked or not addressed.

Some participants identified patients as needing additional screening or follow up for suicide risk management, but the students did not observe this care delivered. Rebecca recounts an experience where she identified a patient with a co-occurring disorder that told her of his plan to commit suicide using pills that were prescribed to him, and that he had access to these pills. “So I went to my preceptor I was working with and I was like, ‘Hey the guy in whatever room, he was suicidal…what do we need to do?’ I’m thinking in my head, okay, what do I know about suicide? Typically we’ll strip a room… and do the suicide precautions” (lines 86-92). Rebecca states that the response she received from her preceptor and the charge RN was that they decided to not place the patient on suicide precautions and instead to wait until the physician could see him. According to Rebecca, once the physician saw the patient, the decision was made to discharge this patient to the community, as there were no psychiatric or substance abuse treatment beds available. “I just felt like it was taken very lightly (line 112)...to me he seemed pretty serious...he had thought out a plan. He had means to a plan” (lines 118-120). Rebecca reports “I don’t believe that anything was done. They said… at this time, we don’t have any places for you. There’s nothing we can do” (lines 135-137). Rebecca continues “I thought it was really surprising that they would discharge somebody … out in the community.... it’s almost like
he’s not serious, but to me he seemed very serious (lines 144-150)...I remember learning in school that most people that commit suicide have been seen in a hospital...so I was thinking, oh, God, is this guy going to be another statistic? (lines 166-175)... I felt like he should have been admitted or further evaluated (lines 186-191)... I felt that they didn’t take him seriously...I don’t think that they provided the treatment that he deserved” (lines 335-336). Rebecca was not privy to the clinical considerations that resulted in the decision to discharge such a patient to the community. Since this information was not provided to Rebecca, she arrived at her own conclusions about this experience, whether accurate or not.

Taylor also described an experience where the staff nurses were not taking a patient’s needs seriously. “And (the patient) looks at us like, well, you’re not going to help me with my basic needs, so why are you sitting here focusing on my...self-actualization...when their basic needs aren’t met...For example, I had a patient who was older, and she was on suicide precautions. But she also had constipation. And that’s pretty typical in our older patients, but a lot of the meds that we give them also cause constipation. And so many of my nurses were telling me, ‘Oh, gosh, she does this all the time’...You know, they weren’t very concerned about the constipation, but my patient was ruminating on the constipation. So I was thinking, well, you know what? Let’s deal with this issue. I know she’s depressed and I know she’s suicidal, and I’m watching that, but she is constipated and she cannot get her mind off that...I worked with the doctor and ...orders that I had – and my nurses, too, even though they...seemed exasperated by my attempts to accommodate my patient. Ah, but we tried the next steps up and it worked. So...I went in and asked her about it, and she said, ‘Oh, I had a bowel movement.’ And she was so excited. And I saw her smile for the first time since she’d been in admission...I think
sometimes in mental health, we get really focused on the mental health issue -- and we have to remember that …even though we say they have somatic complaints…as if they don’t matter. Kind of like that’s not our specialty. But they’re going to focus on those, so we need to make sure that we can do everything we can for those – along with the mental health problem” (lines 533-580).

Maria discusses her first encounter with a suicidal patient who had paraplegia and was homeless. He pushed himself out of his chair, causing an intentional fall. The patient was hopeless, hurting himself and “had no reason to live” (line 77). “Even though he did have a family… it was heartbreaking to see someone so hopeless” (lines 79-80). The patient stated “he didn’t want to be there and didn’t want to live” (lines 90-91). Patient had “ripped out his IV and all of the other things medically to delay treatment or stop treatment” (lines 92-94) and was placed on suicide precautions. The RN this student was working with did not take this situation seriously, as if he could not hurt himself and “it’s not a big deal” (line 106)… Maria said the nurse’s approach to this patient did not align with what she learned in nursing school. Maria felt this patient should be treated as high risk and they needed to make sure that he did not harm himself. Maria recognized the nurse who did not take suicide seriously in this type of patient. Maria explains that she does not think it is safe or appropriate to “ignore someone’s cry for help, regardless whether they want help or not…they told you they don’t want to be there… I think you need to address it”. As a student nurse, Maria describes not knowing how to “handle the situation eloquently” (lines 145-151).

John is another participant that shared a story relating discrepancies between theory and practice. He completed a practicum experience in a busy emergency department (ED) where at
least ten patients a day were seen for suicidal ideation. Here, the patients were triaged and some were sent to the psychiatric observation unit. Patients that were identified as suicidal and waiting for an inpatient psychiatric bed were placed in a one-leg one-arm restraint so they would not harm themselves. John explains “It was such a busy emergency department that we would have to place… their beds in the hallways and line the hallways with these patients while they were waiting for beds in the psychiatric unit” (lines 48-49). John recounts this experience throughout his interview: “Just as calm and caring as you can be for the patient. Like while you’re doing this thing, it’s basically—it’s almost taking away their rights” (lines 96-99). John describes availability and access to care issues where there were not enough rooms in the ED or psychiatric beds to meet the needs of patients. This resource shortage led to restraining and boarding high-risk suicidal patients in the ED, and presented a discrepancy between what John learned in his theory courses, and what he encountered during his practicum experience.

Theme 2: Students Navigating the RN Role. The theme Students Navigating the RN Role was identified in most transcripts. Students looked to their instructors, staff nurse preceptors, and other members of the healthcare team for guidance and they learned expectations within the clinical setting. Nursing theorist Benner (2001) discusses the process of nurses moving from novice to expert throughout their practice, and the centrality of nurse preceptors throughout this mentoring process. Students’ acquisition of the RN role encompasses professional relationships, maintaining professional boundaries, extending hope and support to patients and families, and how students saw themselves emerging into the professional role of RN.
Tessa identifies her nurse preceptor as a positive role model. Her preceptor balanced addressing physical and mental needs, and helped Tessa learn how to manage and prioritize care. Marie explains “The clinical staff and one of my teachers really helped me through my first experience with a patient that was at risk for suicide” (lines 70-74). Liz identifies sadness, anger and frustration because she felt helpless to make a situation better for a girl that had attempted suicide. She notes a lack of hospital resources for families when someone has attempted suicide, and thinks they would benefit. Families and loved ones need resources in order to respond in a helpful way towards the person at risk for suicide. At the time, she did not know the resources that she does now (lines 284-293). In her reflection, Liz says that she could have called her instructor to help her. The instructor probably would have helped and might have suggested a family or psychiatric consult (lines 305-311).

Sally conveyed a sense of optimism and hope about her new role. “Sometimes it just takes one person to be able to trigger something that will…provide influence and a positive energy to… get her through the hard times” (lines 296-298). “So when you’re caring for somebody that’s going through that much of a hardship…be on your top game…it could be you that …. gets her through this hard time in her life. So I think there’s always room for change, and if you’re able to be that positive person to change someone, then you should put your best foot forward” (lines 300-306).

These statements reflect the opportunities and challenges facing students while developing nurse-patient relationships and a therapeutic alliance with patients at risk for suicide. Within the context of clinical practice, students must learn to develop effective therapeutic relationships with patients. The nurse-patient relationship, based largely upon the work of Peplau
forms the foundation for nursing practice, and is necessary in order to achieve therapeutic success (Kneisl & Trigoboff, 2013). However, therapeutic alliance extends beyond therapeutic communication and the therapeutic relationship. Therapeutic alliance suggests a curative, healing relationship between client and clinician that is mutual and collaborative. An alliance implies that care is done with the patient, instead of to the patient. This specific term distinctly identifies the collaborative, therapeutic climate within a helping or therapeutic relationship. It is an active, engaged concept that applies to a variety of healthcare disciplines and settings. Successful treatment of suicidal individuals requires interventions that promote treatment alliance in the context of shared responsibilities for patient safety (Fowler, 2013).

**Theme 3: Relating to Understand the ‘Why’**. A number of students expressed a desire to understand “why” someone could become suicidal. This theme differs from applying knowledge in an effort to identify suicide risk in patient care scenarios. Within the theme **Relating to Understand the ‘Why’**, students express a desire to form therapeutic relationships with patients and struggle to identify how and why someone would want to end their life. Here, students sought to relate to and make sense of complex clinical situations.

Tessa describes never really knowing who could be at risk for suicide and believes that this risk may not be understood until the nurse starts to form trusting relationships with patients (line 57). Maria stated “It helps when you can relate to your patient in a certain way” (line 210). This concept is interesting, because students articulate this need for relatedness as important to effectiveness in work with patients with mental health issues, or at risk for suicide. However, this
sense of needed relatedness is not typically focused upon during the care of patients with other medical issues, such as heart disease or diabetes.

Chrissy describes an experience with a patient at risk for suicide that stands out to her. The patient is a young man and near her same age. He combined alcohol and Tylenol in an overdose attempt. She asked him why that method and he listed off all the reasons he couldn’t do other methods, no gun, shower curtain rod not strong enough, no antifreeze, and “He was young… “After he shared that I asked him about…his relationship with his mom and his sisters. And it wasn’t bad at all” (lines 166-168). Chrissy is trying to grapple with the idea of why the patient would attempt suicide and she states “he never really said why he did it, which was interesting” (lines 176-177). Part of a suicide assessment is to ask all the questions, especially the triggering event and she did not address that. Chrissy explains that these patients stood out to her because she felt connected to them. “I was able to sit down and actually do…interviews with them, but it was more relaxed and they trusted me and we were on a good level in the student nurse-patient relationship. And they shared a lot about their family and themselves and their experiences throughout the years. And so that…made me more connected to them” (lines 205-210).

Individuals in a suicidal state of mind tend to develop psychological constriction, dichotomous “black and white” thinking and negatively skewed thinking patterns (Shneidman, 1996). To the outside observer, individuals at risk for suicide may be perceived as irrational. If the patient’s background and presenting stressors did not seem to rise to the level where the student could understand or relate to why the patient felt suicidal, some students formed clinical impressions that the patient was somehow “out of the woods” or their situation was therefore not
high risk from the standpoint of suicide. These faulty clinical impressions may alter the care and monitoring that patients at risk for suicide receive. However, these impressions may lead to dangerous consequences.

Does student nurses’ desire to feel connected and comfortable interfere with or enhance their ability or willingness to conduct suicide assessments with at-risk patients? In some cases this urge to discover “why” someone is suicidal may distract students from taking measures to assure patient safety. Some participants focused upon their desire for feelings of being “comfortable” instead of upon their role and responsibilities towards patients at risk for suicide. It is important that nursing educators promote accurate and comprehensive management of patients at risk for suicide—regardless of student nurse perceptions of the rationality of suicidal patients, patient motivations, and student sense of comfort and relatedness towards patients.

**Theme 4: Judging vs. Empathizing.** The theme *Judging vs. Empathizing* addresses the social stigma associated with mental illness and suicide. Several students described their own ability to empathize with and advocate for patients, and healthcare workers’ and family members’ attitudes and actions towards those at risk for suicide.

Maria explained that working with a suicidal patient “made me really sad…I have a hard time working with them because even though I’ve learned all about it, I don’t understand what it is or how it feels to be in their feet. I don’t understand…not having a reason to live” (lines 228-234). She adds “it hurts to see people in such despair and so hopeless and helpless…you want to talk some sense into them, but you can’t” (lines 237-238).
Chrissy states “it’s important not to judge…how they were feeling, what led them to that (suicide attempt) or if drugs were in the picture” (lines 297-300). “I think a lot of people think that if someone tries or completes (suicide), that they…must’ve been using drugs or drinking during the time or had a lot of problems, but that’s not always the case” (lines 303-305).

Marie explains “That experience I had…showed me that…people go through awful things that you couldn’t even create in your own mind if you thought about it. It just made me see that for someone to be so low and feel that way, to not judge them and instead try to help or see how they’re feeling. So I think…having that experience, I kind of had a change of thought in my head. Because even with my family, if they’re like, ‘Oh, they’re fine. You know, it’s just a bad day,’ or, ‘they need to buck up and move on.’ I’m more willing to step up and…back them up a little bit and say, ‘Hey, you don’t know what happened. You don’t know what happens in their home life. Why don’t we take some time and get to know this person before we judge…their thoughts or their actions?’ I definitely think my experiences and my thought processes have changed because of the experiences throughout nursing school” (lines 358-379).

Abby explains that as a result of her experiences, her eyes have been opened to “the real need for better mental health care and the true mental struggles that just go unnoticed by the rest of society” (lines 171-175). Outside of nursing, suicide was secretive, separated from society-- a “taboo topic… no one really wants to talk about it because it makes you feel uncomfortable and sad… it’s hard… there are many layers and levels to it. In order to avoid the uncomfortableness… it’s easier to pretend it isn’t happening… it has taught me to be more aware of people in everyday life… to not be afraid to ask and listen … withhold judgment… because that is what is going to help people” (lines 189-194). Abby also noted the conflicting thoughts
and feelings that emerged during her work with suicidal individuals – from “sadness and compassion” to “There was this other side… frustrating… suicide can be very selfish… look at all the people you are leaving behind to suffer” (lines 287-298). Marie also identified that prior to nursing school, she tended to view suicidal individuals as selfish (lines 351 and 356).

Liz detected judgmental attitudes by the nurses and parents towards a pediatric patient that had attempted suicide. She sees this as unproductive, given her observation of the patient’s responses (lines 163-170). “I (will) make sure that I don’t ever go into a room with that kind of mentality… the way her parents were going about it… she just shut down” (lines 172-178).

Through her experience, Liz saw that an angry, accusatory and blaming approach towards communicating with someone that attempted suicide blocked communication. Taylor found that psychiatric or suicidal patients placed on various units were not treated respectfully by the healthcare workers (lines 160-162). Abby’s awareness of the value of countering this dynamic has expanded beyond healthcare settings. She has learned in everyday life to “withhold judgment because that is what really is going to help people” (line 189).

These findings align with research. Several provider factors have been found to interfere with proper screening and identification of suicidal patients. These factors include limited knowledge of acute and chronic suicide risk factors, and negative attitudes towards patient suicidal behavior (Botega, et. al, 2005). Ghio et al., (2011) found that individuals who survived a suicide attempt identified interpersonal relationships and an empathic environment as therapeutic. This empathic environment enabled the expression of thoughts and self-understanding, and was protective against suicide. It is important that nurses apply these
principles in their patient care in order to promote favorable outcomes in the care of individuals at risk for suicide.

**Theme 5: Managing Stress and Emotion.** This was a common theme in many interviews and includes students managing the stress and emotion of patient care, managing their responses to these patient encounters, and managing their concerns about developing burnout over the course of their nursing careers.

Many students described experiences referred to in the psychiatric and mental health literature as *countertransference*. *Countertransference* is a state in which unresolved past conflicts within the healthcare provider are unconsciously ‘counter transferred’ or directed towards a patient (Lakdawala, 2015). If left unaddressed, *countertransference* can have implications for patient-provider boundaries and may lead to changes in provider behavior towards patients. All students described the intrapersonal and interpersonal challenges of working with patients who were at risk for suicide.

Marie recognized that her personal emotions stood out to her during her encounters with patients at risk for suicide (lines 93-106). During these times, Marie remembers feeling “shock” (line 115), feelings of hopelessness (line 127), disbelief (line 129), sadness and anger (line 324). Tessa used the word intimidated thrice when asked about her emotions that stood out to her. “It was almost like I was handling something very fragile to me (line 432)…at first the feelings were very rocky and intimidating” (line 441). Tessa continues to describe feeling nervous and timid. She then explains that “the first thing that popped in my head is I need to form this trusting relationship…and that’s kind of what calmed me down (lines 446-447)… I started to feel more
relaxed (lines 465-466)… more empowering… like I can help her” (lines 468-469). Tessa identifies feeling nervous. She felt that the patient could tell this which she believes affected how the patient responded to her, as evidenced by her lack of eye contact and brief one-word answers. If Tessa could do it differently, she would convey more confidence, and would ask for help from other work colleagues. She thinks that coming in with a sense of confidence “affects the way the patient looks at you and the relationship you are going to have for the entire shift” (lines 577-578). She goes on to explain that because of her nervousness and timidity, she was not able to address the patient’s needs as well as she could have (lines 582-585).

Students found that dealing with suicidal patients carries over into other aspects of life. Some students identified acute physical or emotional stress reactions and stress-related somatic concerns. Sarah explained “Working with people who are at risk for suicide or have attempted or have been unsuccessful …it is emotionally tiring for a nurse or student nurse…I’ll start to get stressed out and then maybe I won’t sleep very well. And then I’ll start to get headaches and then I’ll be more grumpy. It’s just that cascade of events” (lines 533-539). After caring for a pediatric patient that had attempted suicide, Liz went home, cried and told her fiancée “this is not a good day for me right now… I need to chill for a bit and not do much of anything” (lines 224-226). She explains that this experience changed her perception and helped to solidify that she does not want to enter a room in the manner that the patient’s parents did (lines 229-234).

Abby explained that her nursing school experiences and interactions with mentally ill and suicidal patients “Made me grow up a little bit faster or mature a little faster…It showed me the harsh reality of what people… are going through that is outside of my own life and my friends’ lives and everything I knew growing up” (lines 153-160). She describes her experiences as very
different from those of her non-nursing major peers, which made it difficult to relate to her peers. She discusses the need to compartmentalize and not take things into her personal life, but this is hard to do (lines 166-170).

Jo recalls her work with adolescents that were receiving mental health and substance abuse treatment, many of whom were considered at risk for suicide. “I had never seen such disparity, so many kids with really screwed up background where their parents abused them, or forced drugs on them, so they became addicted. And I had my eyes opened to a whole new world to something that I didn’t know existed. As a healthcare worker, you want desperately to help these people. But I have struggles since then actually with questions of what I can do. And I don’t know. I have no idea how to fix the issue” (lines 271-278).

Jo goes on to describe a situation. “There was a child that I came in contact with who was in an outpatient program. I think he was about eight and was constantly speaking about death and killing others, killing himself—it was incessant talk. And I never expected that out of an eight year old…what kind of situation was putting him into this frame of mind that he was obsessing with thoughts of death? And just thinking… it all comes back to the families. How are we supporting the families? As soon as we had done good for them in that day program and then we walked back out with their parents, you saw the same old kind of patterns kick in again. And then they came back. And how are we helping them adjust… and getting the parents involved with…teaching their children the better way of life…rather than perpetuating their frame of thought or their behavior patterns? And wishing that I could do something instead of the constant, oh, let’s medicate everything in everyone—to find something more sustainable” (lines 300-331).
Some students expressed concerns of a contagion-type effect from working with patients at risk for suicide. Chrissy gets a “low feeling after talking to them. Like, wow, you know, they’re a person. They’re important, and I wish that they didn’t think that was their only option at that time” (lines 447-450). She mentions again the young man who had all this talent with his hobby “it could’ve been wasted if he had been successful with his attempt (lines 458-459). Talking to them hits it home that they are humans and they are suffering, struggling with something that they have difficulty understanding.” Then she states, “Sorry, I’m having a hard time” (line 493) and pauses to regain her composure.

John expresses similar concerns well. “When it’s mental health issues like suicide, it’s like this could happen to anybody and this could happen to me, it could happen tomorrow” (lines 446-452). John then describes suicide risk as scary. “They could see it happening to them and they don’t want it to” (lines 454-455). John refers to the nurse ‘catching’ suicidal thoughts and feelings. “If patients talk about their feelings, you’re like, oh, I experienced that feeling too, does that mean I’m going to develop suicidal tendencies?” (lines 468-470).

The fear of developing burnout was also a recurring topic in this theme. Rebecca struggled and found herself experiencing doubts about her future career goals as a result of seeing the suicidal patient that she was caring for being discharged from the ER to the community. “I don’t know if it’s just that they’ve been in the ER for so long that they’re used to working with psych patients who present this way….that this is a common thing to… blow off, but I don’t really think it was appropriate. I wanted to work in the ER for quite a while. That’s the area of nursing that most interests me…but I found myself wondering after that…in a way kind of the typical nurse burnout story where you just don’t really think anything is serious after
you’ve been working in the ER too long…. After you’ve been working in that field for a long
time, it’s kind of easy to let that happen. So I found myself just kind of questioning how I would
prevent that from happening…if I work in that field…after ten years of doing that I’m not going
to…blow off someone who’s presenting with suicidal ideation” (lines 283-285). Abby goes on to
discuss the risk of compassion fatigue and burnout in nursing. “The struggle of dealing with
situations in your work, then leaving those when your shift is over and interacting with the rest of
society…to find that balance (line 230)”. She discusses the importance of self-care in nursing.
John also identified the challenges of dealing with intense emotions and concerns over
becoming ‘jaded’. “I think it just, ah, from repeated exposure to having to deal with raw
emotions that it makes a person more likely to develop a harsher view of patient care” (lines 232-
234). Another person that this reminds him of is a recent graduate nurse and John describes him
as saying this “being jaded is a choice and that you know at some point down the line you begin
making choices to not consciously think about the patients that you’re caring for because you’re
just tired of dealing with it, of dealing with the patients” (lines 245-248). He wished he would
have heard this other nurse’s viewpoint on being jaded when he was a student working on the
psych units described above because “I think I probably could’ve provided better care or been
more open to what patients were saying, um rather than what I think about now is I think that I
might’ve written some patients off about what they were saying or how they were feeling just
based on their history” (lines 267-271). John is also concerned that he doesn’t want “their
feelings (jaded nurses) to transfer onto mine and my care reflect to theirs” (lines 295-296).
Theme 6: Expecting the Unexpected. Am I missing something? Will I say the wrong thing? *Expecting the Unexpected* was another identified theme. A number of students expressed concerns that they might miss or not identify an important piece of assessment data, or something that a patient might say to suggest that they are at risk for suicide. This theme extended beyond expected role performance, and reflected students’ real concerns that given their training and education, or the demands of the RN role, that they may miss a critical piece of evidence which could indicate that a patient is at risk for suicide.

Abby acknowledges her fear and nervousness of missing something or saying the wrong thing to upset the patient (lines 340-341). Jackie discusses challenges that nurses face prioritizing care while simultaneously managing patient’s physical and psychological needs “They’re not in a position yet to be helped psychologically…. you’re just there with them physically… you’re trying to get them medically stabilized first” (lines 127-132). “It’s really hard as a nurse…we’re going and going and going…people could slip through the cracks without getting enough help based on the fact that… we’re moving between patients” (lines 113-116).

Sally explains that as a result of her experience caring for a pediatric patient with a history of multiple suicide attempts, “It showed me that I needed to show more caution…be careful with the questions I was asking, but it also showed that I needed to be very attentive. If she had this many attempts, clearly something was going on. And in-between the attempts, something isn’t helping the situation…because you have patients that have tried to commit suicide once, and then there they move forward and they kind of do okay the rest of their lives” (lines 286-291). “But clearly something is not getting better, whether it’s her medication she’s taking, or she’s had counseling that’s not helping or if it’s her family life. Clearly something’s
not getting better” (lines 293-295). “I think that these experiences have taught me to be more aware of the interactions that I’m having with individuals and how to pick up on the little signs that you wouldn’t normally know are signs of suicide” (lines 471-475). Marie adds “To this day, I think I’m just more reflective in my nursing career. I pay a little more attention to things my patient says” (lines 332-333).

Taylor shared that she observed that chronically suicidal patients with a history of multiple suicide attempts are not taken seriously. “You hear that from the nurses. And they’ve had a lot of previous admissions…that doesn’t mean we shouldn’t take them seriously. We’ve had training on that. Every attempt or every… indication that they’re going to commit suicide should be taken seriously. But I think sometimes…they just cycle through and you think, oh, they’re going to be okay because they’ve been here before. This is just a cycle. But I’ve had nurses tell me, you know, sometimes it’s alarming when you don’t see them again. And then you wonder what happened to them” (lines 183-197).

Marie learned to always conduct suicide risk and mental status assessments on all patients. “I realized how important it is to actually take that first suicide assessment very seriously… then if their status changes or you notice certain things, do that assessment again” (lines 164-168). “Just never let your guard down…Even the patients that seem really happy, they have a great support system, sometimes those are the ones that can get the lowest” (lines 170-173). “You just have to remember that they’re hurting inside” (line 181). “Life can get rough, but, you know, other people’s lives are going to be worse. And just taking that time to look into their history, looking into their background, seeing what they’ve been through, and then just trying to pull in the needed resources that they need, whether that be social work or…a psych
consult or something like that. But I just think overall just taking every little statement that a patient says seriously. I mean, even we’ve been taught, you know, that pain is the fifth vital sign and you always believe what the patient says about pain. But I think with suicide it’s the same thing. You always believe what a person says about suicide. You don’t take it as a joke or, oh, you’re not serious. Um, you take it very seriously, even if your patient was super happy thirty minutes ago. Because we learned when someone decides that they’re going to kill themselves, they usually do get that happiness or kind of lightening” (lines 388-405). “I learned throughout nursing school that (suicidal) people will tell you if you ask” (lines 513-514). Julie adds “A lot of times (patients) just want to be heard…show them that it is important to hear what they’re feeling” (lines 337, 343). “I have learned as I embark on my new career that (listening to patients) is just as important as checking somebody’s vital signs” (lines 347-349). These findings align with recent evidence that identified nurse-patient engagement as one of the key elements that affects safety in psychiatric treatment environments (Polacek, et al., 2015).

**Composite Textural-Structural Description of the Meanings & Essences**

During analyses of the transcript data, the following six themes were identified:  
*Integrating Theory and Practice, Navigating the RN Role, Relating to Understand the ‘Why’, Judging vs. Empathizing, Managing Stress and Emotion, and Expecting the Unexpected.* What follows is a composite textural-structural description of the meanings & essences of the experience of student nurses while caring for patients at risk for suicide.

These interviews convey the sense of awe and deep compassion that students develop towards the suffering of other individuals (Howell, 2015). Students realize that someone else’s
suffering (thoughts of ending one’s life) directly affects the self-- both in and out of the nursing role (Howell, 2015). It is noted that most of the participants used depersonalizing language throughout their interview, referring to themselves in the second person. Depersonalizing language may be used consciously or unconsciously as a means to distance oneself from difficult subject material. Students recognize the need to develop a nursing role-identity, the need for self-care, and the need for improved access and availability of mental healthcare services. Students recognize the concerns and responsibilities of the RN role, which involves being entrusted with the lives and safety of others. Student expressed both doubt and hope about their ability to manage the complex challenges facing nurses today while caring for patients at risk for suicide.

Summary

Student nurses were interviewed about their experiences while working with patients at risk for suicide and they described their encounters. The following themes were identified during phenomenological analysis of interview transcripts: Integrating Theory and Practice, Navigating the RN Role, Relating to Understand the “Why”, Judging vs. Empathizing, Managing Stress and Emotion and Expecting the Unexpected. These descriptive themes can help educators, healthcare professionals and researchers understand the experience of student nurses while caring for patients at risk for suicide. This study offers implications for education, practice, policy and research. These implications are discussed in chapter five.
CHAPTER FIVE
IMPLICATIONS, LIMITATIONS AND CONCLUSION

Implications

The purpose of this study was to describe the experience of student nurses while caring for patients at risk for suicide. The implications of this research as it relates to education, practice, policy and research are discussed below.

Nursing Education. The findings in this study have implications for undergraduate nursing education. According to Heyman, Webster, & Tee (2015), student nurses need appropriate pedagogical methods and support as they prepare to care for patients at risk for suicide. They found ASIST training to be an emotionally challenging yet positive experience for second year BSN students. They identified the following educational needs: evidence-based suicide prevention preparation geared towards providers working with psychiatric emergencies in non-psychiatric clinical settings as well as mentoring and practical support for students managing acutely suicidal patients. Pullen, Gilje, & Tesar (2015) found that BSN nursing students responded positively to the QPR suicide prevention gatekeeper training program.

While the role of caring for patients at risk for suicide has historically been designated to occur within psychiatric settings, this is no longer the case. Many participants recounted experiences with patients at risk for suicide in non-psychiatric settings. Such challenges may leave some students feeling inadequately prepared to manage patients experiencing high-risk psychiatric situations. Just as it is necessary to prepare nurses of all specialty areas how to
perform Basic Life Support (BLS) and effectively respond to medical emergencies, it is also important to prepare nurses of all specialty areas how to effectively respond to psychiatric emergencies. Students must be trained to respond appropriately to patients’ suicide risk. Nursing education should incorporate preparation geared to the generalist nurse, and include didactic, role play or simulation scenarios, as well as evidence based clinical instruction and practice in the basic skills of suicide screening, assessment, management and prevention services.

**Nursing Practice.** The findings in this study have implications for continuing education, training and support for nurses in their work with patients at risk for suicide. Nurses need more knowledge of acute and chronic suicide risk factors, suicide warning signs, and should be educated to develop therapeutic attitudes and responses towards patients at risk for suicide (Botega, et al., 2005). Nurses that apply these principles can promote more favorable outcomes in the care of those at risk for suicide.

Caring for suicidal patients requires nurses to balance many competing demands. Often these demands involve prioritizing and providing care in medically complex situations, sometimes without the proper resources, staff and support structures in place.

Psychiatric emergencies such as suicidality often arise in non-psychiatric settings such as general hospitals, emergency services, or doctors’ offices and give rise to stress for all persons involved. They may be life-threatening and must therefore be treated at once… The existing evidence suggests that the diagnosis and treatment of psychiatric emergencies need improvement (Mavrogiorgou, Brüne, & Juckel, 2011, p. 222-223).
Nurses practice on the front lines of patient care, and can be educated and trained to become more effective in patient teaching and delivery of interventions to prevent suicides, regardless of the setting in which they work.

Healthcare Policy. The findings in this study have implications for healthcare policy. Hospital policies informing how we provide care for patients at risk for suicide should be evaluated and revised in keeping with changing risks to patient safety. These policy evaluations should be conducted of medical/surgical units and emergency departments. According to the Joint Commission’s 2010 Sentinel Event Alert:

While psychiatric settings are designed to be safe for suicidal individuals and have staff with specialized training, typically, medical/surgical units and emergency departments are not designed or assessed for suicide risk and do not have staff with specialized training to deal with suicidal individuals. Not surprisingly, suicidal individuals often are admitted to general hospitals immediately following suicide attempts, or they seek help in hospital emergency departments – often at the urging of families or friends – when they are most desperate. These patients are “known at risk” for suicide. It is noteworthy that many patients who kill themselves in general hospital inpatient units do not have a psychiatric history or a history of suicide attempt – they are “unknown at risk” for suicide. Compared to the psychiatric hospital and unit, the general hospital setting also presents more access to items that can be used to attempt suicide – items that are either
already in or may be brought into the facility – and more opportunities for the patient to be alone to attempt or re-attempt suicide.

(The Joint Commission, 2010, p. 1)

Indeed, the Joint Commission’s report addresses areas where advances in healthcare policy can directly impact patient care, patient satisfaction and patient health outcomes.

Health care reform and mental health parity laws can increase access to mental health and addiction prevention, screening, treatment and recovery support services. These measures and increased availability of treatment resources can have a significant impact upon reducing the number of suicides that occur in the United States each year (American Foundation for Suicide Prevention, 2015).

Continuing education requirements must also be considered. A number of state licensing boards now require that nurses receive ongoing suicide prevention training as part of continuing education requirements. In June 2012, Washington became the first state in the nation to require mental health professionals and other frontline care providers to receive training in suicide assessment, treatment and management (Washington State Department of Health, 2014).

**Nursing Research.** The findings in this study have implications for future research in the areas of suicide prevention, intervention and management. More research is needed in the area of nurses’ work with patients at risk for suicide, both in psychiatric and non-psychiatric settings. Additional research can address nursing education, nursing practice and healthcare policies which promote efficacious suicide prevention and intervention methods. Work related topics such as nursing workload, nursing job satisfaction, nursing workforce retention, and
multidisciplinary care of suicidal persons can also be explored. Suicide prevention research should be directed towards groups at high risk for suicide, including youth, the elderly, males, Caucasians and Native American populations. Additional research is needed in the areas of violence prevention, firearm safety, mental health first aid training and serving veteran populations, as these areas relate to suicide prevention, intervention and management.

Limitations

A limitation of this study is that little heterogeneity exists within the sample. The study was conducted with groups of students from two universities located in Eastern Washington State. While most of these students were originally from the Pacific Northwest, some were originally from other locations within the United States. The sample was predominantly young adults in their early 20s, with the exception of one participant that was in her early 40s. The sample was vastly of the female gender, with 13 of the 14 participants identifying as the female, and one participant identifying as the male. The majority of the participants were white. Thus, this sample was representative of predominantly white, young adult female BSN students from the Pacific Northwest. In order to represent a more heterogeneous population, procedures would have to be implemented in order to recruit a more diverse participant sample.

Conclusion

The aim of this research was to generate a comprehensive description about the experiences of student nurses while caring for patients at risk for suicide, using transcendental phenomenology. Six general themes were identified. Students identified instances during suicide
risk screening and management where theory was not applied to practice in a complementary manner. Students expressed a lack of confidence in regards to properly identifying and responding patients a risk for suicide. Students identified instances where professionals and lay people conveyed empathy or judgmental attitudes towards individuals at risk for suicide. In these instances, students tried to promote patient advocacy, yet expressed concerns about their ability to effectively do so. Students struggled to manage their own emotional reactions towards working with patients at risk for suicide, and some expressed fear of a possible “contagion effect” while working with suicidal individuals. Students wanted to connect with patients and feel comfortable while providing care, and such motivations may have influenced their clinical decision-making and actions. Overall, students communicated a need for more education, resources and support towards preventing suicides. These findings can inform future education, practice, policy and research in the areas of suicide prevention, intervention and management.
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Hello BSN Students and BSN Alumni:

- Have you encountered a patient that may have been at risk for suicide?
- Would you like to participate in important healthcare research?
- Would you like to make $20?

If this applies to you, I would like to interview you!

My name is Jennifer and I am a WSU PhD in nursing student. If you are a BSN student or BSN alumni, and willing to be interviewed to discuss your experience, please email, call or text me!

Jennifer Miller, PhD(c), RN, LMHC
jennifer.miller2@email.wsu.edu
(509)701-7349
APPENDIX B

Pre-interview Screening Questions

Inclusion Criteria Questions:
Do you speak English? ____________
Are you age 18 and over? ____________
Are you a senior-level BSN student or alumni? ____________
Have you received class and clinical instruction in suicide prevention/screening procedures? ____________
Are you pre-RN or post-RN licensure? Pre
Post When RN license obtained _______
Have you had at least one encounter with a patient at risk for suicide? ____________

Exclusion Criteria Questions:
Do you have a prior earned degree in a mental health related field or have you worked in a psychiatric mental health-related field? ____________
Are you having current thoughts of suicide? ____________
Are you involved in any other research study at this time? ____________

Demographic Questions:
Pseudonym: ________________
Gender: Male
Female
Age: ________________
Thank you for your willingness to talk to me and share your experience. I am attempting to understand your experience as a student nurse by listening to your story about caring for patients at risk for suicide. Your unique story may be used to help educators, researchers and healthcare professionals more fully understand the experience of student nurses working with patients at risk for suicide. There is no right answer; nothing you share will be wrong. There might be pauses and this is fine; take whatever time you need to think or reflect. If you feel uncomfortable or want to end the interview at any time this is fine; just let me know. Our meeting is completely confidential; what you share will not be linked to you. Do you understand this introduction? Do you have any questions?

Opening questions:

(a) “Please recall and tell me about your experience while caring for patients at risk for suicide.”
(b) “What contexts or situations have influenced or affected your experience caring for patients at risk for suicide?”

Additional open ended questions:

1. What dimensions, incidents and people intimately connected with the experience stand out for you?
2. How did the experience affect you? What changes do you associate with the experience?
3. How did the experience affect significant others in your life?
4. What feelings were generated by the experience?
5. What thoughts stood out for you?
6. What bodily changes or states were you aware of at the time?
7. Have you shared all that is significant with reference to the experience? (Moustakas, 1994, p. 116)
APPENDIX D

Applications of Descriptive Phenomenology to Human Science Research

The following principles, processes, and methods summarize the core facets of human science research.

1. Phenomenology focuses on the appearance of things, a return to things just as they are given, removed from everyday routines and biases, from what we are told is true in nature and in the natural world of everyday living.

2. Phenomenology is concerned with wholeness, with examining entities from many sides, angles and perspectives until a unified vision of the essences of a phenomenon or experience are achieved.

3. Phenomenology seeks meanings from appearances and arrives at essences through intuition and reflection on conscious acts of experience, leading to ideas, concepts, judgments, and understandings.

4. Phenomenology is committed to descriptions of experiences, not explanations or analyses. Descriptions retain, as close as possible, the original texture of things, their phenomenological qualities and material properties. Descriptions keep a phenomenon alive, illuminate its presence, accentuate its underlying meanings, enable the phenomenon to linger, retain its spirit, as near to its actual nature as possible…

Phenomenology is rooted in questions that give direction and focus to meaning, and in themes that sustain an inquiry, awaken further interest and concern, and account for our passionate
involvement with whatever is being experienced. In a phenomenological investigation the researcher has a personal interest in whatever she or he seeks to know; the researcher is intimately connected with the phenomenon…

Subject and object are integrated—what I see is interwoven with how I see it, with whom I see it, and with whom I am. My perception, the thing I perceive, and the experience or act interrelate to make the objective subjective and the subjective objective.

At all points in an investigation intersubjective reality is part of the process, yet every perception begins with my own sense of what an issue of object or experience is and means.

The data of experience, my own thinking, intuiting, reflecting, and judging are regarded as the primary evidences of scientific investigation.

The research question that is the focus of and guides an investigation must be carefully constructed, every word deliberately chosen and ordered in such a way that the primary words appear immediately, capture my attention, and guide and direct me in the phenomenological process of seeing, reflecting and knowing. Every method relates back to the question, is developed solely to illuminate the question, and provides a portrayal of the phenomenon that is vital, rich and layered in its textures and meanings.

(Moustakas, 1994, p. 58-59).