2014

An interpretive study of nursing students' experiences of caring for suicidal persons

Martha M. Scheckel
University of St. Thomas, Minnesota

Kimberly A. Nelson

An Interpretive Study of Nursing Students' Experiences of Caring for Suicidal Persons

MARTHA M. SCHECKEL, PhD, RN* and KIMBERLY A. NELSON, MSN, RN†

Suicide is a worldwide public health problem. Although preparing nursing students to care for suicidal persons has been a standard part of nursing education for many years, nurses consistently report that they lack competencies in caring for this population of patients. The purpose of this phenomenological and hermeneutical study was to understand the experiences undergraduate nursing students had in regard to caring for suicidal persons. The aim of the study was to obtain insights into the basic preparation of students in the care of suicidal persons to inform pedagogical approaches pertaining to suicide and improve the nursing care for these individuals. Twelve senior nursing students were recruited for the study. Data were collected using in-depth, unstructured interviews. The study themes indicated that (a) when participants read about suicidal persons' mental status and behavior in patient, records they initially feared interacting with and caring for these individuals; (b) participants' abilities to gather information about suicide risk was influenced by how much patients talked with them about their suicidal tendencies; and (c) participants' capacity to provide safe and therapeutic suicide prevention interventions was impacted by judicious critical thinking skills. Teaching strategies that align with the themes are provided. (Index words: Student nurse; Suicide; Suicide education; Teaching strategies; Phenomenology; Hermeneutics; Interpretive research) J Prof Nurs 30:426–435, 2014.

SUICIDE IS A widespread public health problem. According to the World Health Organization (2012), suicide is among the top 20 causes of death in the world, with nearly 1 million individuals succumbing to it each year. In the United States alone, suicide is the 10th leading cause of death for all age groups with more than 30,000 individuals dying from suicide annually (Centers for Disease Control and Prevention, 2012). These global and national suicide rates may be even greater because unsuccessful suicide attempts are often underreported (Bertolote & Fleischmann, 2009). While the suicide rates are alarming, it is equally disquieting that up to 75% of individuals who committed suicide saw a primary care provider 30 days before their death (Feldman et al., 2009), making suicide detection a "prevalent and preventable" clinical error (Oravecz & Moore, 2006, p. 269).

There have been a multitude of efforts to curb suicide rates. International and national governmental agencies have developed goals, objectives, guidelines, and reports to support health care professionals in detecting, preventing, and managing suicide (U.S. Department of Health and Human Services, 2013; U.S. Department of Health and Human Services Office of the Surgeon General and National Action Alliance for Suicide Prevention, 2012; World Health Organization, 2012). Increased funding for suicide research has resulted in a greater understanding of suicide risk factors (Nock et al., 2009) and the development of suicide risk assessment instruments (Aflague & Ferszt, 2010). The Joint Commission (2013) has a "behavioral health care national safety goal," requiring

*Professor and Chair, Department of Nursing, Winona State University, Winona MN.

†Assistant Professor, Viterbo University School of Nursing, Nursing Center 422, LaCrosse, WI.

Address correspondence to Dr. Scheckel: PhD, RN, Associate Professor and Undergraduate Programs Director, Michigan State University College of Nursing, Life Sciences Building, 1355 Bogue Street, Room #A227, East Lansing, MI 48824–1317. E-mail: Martha.Scheckel@hc.msu.edu, knelson@viterbo.edu

8755-7223

http://dx.doi.org/10.1016/j.profnurs.2014.03.003

health care professionals to identify and provide interventions for those at risk for suicide. Despite the efforts to decrease suicide rates, the total disease burden from suicide is expected to rise from 1.8% to 2.4% by 2020 (Bertolote & Fleischmann, 2009, p. 97).

Amid the current climate of suicide, nurses are vital to the care of suicidal persons. Some authors have indicated that nurses effectively care for suicidal persons through their ability to establish therapeutic relationships (Sun, Long, Boore, & Tsao, 2006; Valente, 2002). Their "therapeutic use of self" (Stuart, 2013) facilitates the "lifesaving goals" of suicide care (Billings, 2003, p. 176). Conversely, numerous authors have documented that nurses consistently report that they do not have the knowledge or skills to provide therapeutic care for those at risk for suicide (Aflague & Ferszt, 2010; Keogh, Doyle, & Morrissey, 2007; Valente & Saunders, 2004). Nurses' lack of preparation in caring for suicidal persons occurs despite prelicensure education guidelines (International Society of Psychiatric-Mental Health Nurses & American Psychiatric Nurses Association, 2008) and practice policies (The Joint Commission, 2013) about suicide assessment, prevention, and management strategies.

Suicide trends, suicide risk assessment research, suicide prevention guidelines and policies, and nursing education about caring for suicidal persons indicate that nurses have an evidence base from which to provide care for suicidal persons. However, their reported lack of preparation in caring for suicidal persons point to a need for understanding how undergraduate nursing students learn to care for these individuals. Obtaining insights into the basic preparation of students in the care of suicidal persons can inform pedagogical approaches pertaining to suicide and can improve the nursing care for these individuals. The purpose of this study, therefore, was to seek an understanding of the experiences undergraduate nursing students have in regard to caring for suicidal persons by asking them about their experiences of assessing suicidal ideation. The focus on students' assessment of suicidal ideation stems from the fact that questioning patients about suicidal ideation is the most commonly used approach to beginning a suicide risk assessment (Welton, 2007) and one that students are taught to use when initiating care for suicidal persons.

Literature Review

The research on teaching undergraduate nursing students about suicide is sparse. The few studies that do exist describe students' knowledge and attitudes about suicide and their skills in providing suicidal care. To determine knowledge and attitudes about suicide, Kawanishi et al. (2006) administered a questionnaire to groups of nursing students, psychiatric nurses, and social workers. They compared the findings between these groups with a group of medical students who had previously completed the questionnaire. The findings suggested that all of the groups lacked knowledge about suicide. In particular, the groups were unable to identify common suicide risk factors and were unaware that suicide was a major public health problem. In addition, all of the groups had empathetic attitudes toward suicide victims. However, they reported attitudes of unconcern or "no comment" about suicide, which the authors also attributed to a lack of knowledge about suicide.

Other studies regarding students' knowledge and attitudes about suicide have included those evaluating the effect of suicide educational interventions. Sun, Long, Huang, and Chiang (2011) conducted a quasi-experimental study with 174 second year nursing students to investigate learning outcomes following an educational program about suicide. The experimental group learned about theoretical perspectives of suicide and nursing care for suicidal persons, whereas the control group did not receive the educational program. Study findings indicated that, as compared with the control group, the experimental group demonstrated more nonjudgmental attitudes about suicide, better understood that suicide can coincide with mental illnesses, and had a greater understanding that suicidal persons wanted help to alleviate "psychic pain" (p. 842). Pederson (1993) conducted a similar study with 51 senior nursing students. The experimental group participated in an interactive structured controversy session where they debated, for or against, the need for nurses to provide suicide prevention interventions. The control group received a lecture about suicide. As compared with the control group, the experimental group had more accepting attitudes (e.g., less stress and frustration) about caring for suicidal persons. Conversely, compared with the experimental group, the control group had more positive beliefs about their abilities to care for suicidal persons.

In addition to studies examining students' knowledge and attitudes about suicide, a few studies focused on developing and evaluating students' suicide risk assessment skills. Robinson-Smith, Bradley, and Meakim (2009) used a descriptive design to evaluate 112 junior undergraduate nursing students' perceptions of satisfaction, self-confidence, and critical thinking following an activity where the students used textbooks and other literature to prepare for performing a suicide risk assessment with a depressed standardized patient (SP). The findings indicated that students were satisfied with the learning experience and did perceive increased self-confidence and critical thinking in suicide risk assessment. However, the authors reported that the students did not extend risk assessment beyond asking the SP about suicidal ideation. For example, they did not include other components of suicide risk assessment such as asking the SP about self-harm plans. Consequentially, the students did not demonstrate skills in obtaining safety contracts (patients' agreement to inform staff about suicidal ideation) or patient education about 15-minute suicide safety checks. This study is consistent with an earlier study, which suggested nursing students do not adequately learn the skills necessary for reducing inpatients' risk for self-harm (Hazell, Hazell, Waring, & Sly, 1999).

Research suggests that nursing students need additional knowledge about suicide. Studies also indicate that special programming, lectures, and interactive sessions about suicide positively impact students' knowledge and attitudes about suicide and the care of suicidal persons. However, studies also show that students do not have the requisite skills needed to implement suicide prevention nursing interventions. Understanding how students are caring for suicidal persons is necessary in order to learn new ways to better prepare them to care for suicidal persons once they enter nursing practice.

Research Design

The investigators used phenomenology (Heidegger, 1927/1962) and hermeneutics as the research design (Gadamer, 1960/1989). Phenomenology permitted an "unfolding, explicating, and laying out" of students' experiences (Caputo, 1987, p. 53) of caring for suicidal persons. Consistent with Heideggerian phenomenology, the researchers assumed that students' experiences would include expressions about what concerned them most (Heidegger, 1927/1962, p.83). Hermeneutics provided an approach through which the investigators could interpret the students' experiences for meanings. Consistent with Gadamerian hermeneutics, the researchers assumed that interpreting the meanings of the students' experiences would disclose how they were caring for suicidal persons in clinical settings. Their use of hermeneutics would also uncover new understandings (Gadamer, 1960/1989; Palmer, 1969) of students' care of suicidal persons.

Sample

Following institutional review board approval, the investigators recruited 12 senior, baccalaureate nursing students to participate in the study. The students recruited were in a class of 24 students who had completed a 7-week long psychiatric/mental health nursing course as part of their nursing curriculum at a private midwestern university. At the time of the study, the school of nursing within the university enrolled 88 nursing students each academic year. The students completed the clinical portion of the course in a 28-bed, acute inpatient psychiatric/mental health unit within a 325-bed comprehensive regional health care center located in an urban area. The 12 students were recruited because one of the investigator's was their clinical instructor for the clinical portion of the course and she had established a rapport with the students. This rapport importantly increased the potential for gathering rich data about the student's experiences of caring for suicidal persons (Dickerson-Swift, James, Kippen, & Liamputtong, 2007; Fontanna & Frey, 2008). In addition, the student's recent knowledge and experiences of caring for suicidal persons increased the potential for gathering information-rich data. Because one of the investigators was the student's clinical instructor, the investigators recruited the students after they had received their grade for the course.

The investigators recruited students by e-mailing them the study description and purpose and inviting them to an informational session about the study. All 12 students attended the informational session where they received a verbal description of the study and had the opportunity to ask questions about participation. Following the informational session, all of the students agreed to participate in the study and signed consent forms. They were all Caucasian females between the ages of 21 and 26 years. One student later withdrew from the study for an undisclosed reason. It is important to note that the small sample size in this study is appropriate considering that investigators using phenomenology and hermeneutics use a case-orientated, topical approach to data analysis (Moules, 2001). For the purposes of this study, case orientation involved understanding each of the participant's experiences separately and comparing experiences (cross-case comparisons) to create phenomenologies (common meanings of participants' experiences); (Sandelowski, 1995; 1996, p. 527).

Data Collection

Data were collected using unstructured, audio-taped interviews. All of the interviews were face-to-face and were conducted in a private location at a mutually agreed upon time. The investigators began each interview with the following open-ended question: "You have just completed your psychiatric/mental health nursing course. During the clinical rotation you learned how to assess a patient for suicidal ideation. Can you tell me about a particular time when you were assessing a patient for suicidal ideation and what that experience meant to you? Tell it in as much detail as you can as if you were at that moment in time again."

As participants described their experiences, the investigators probed for details by asking them questions such as "Can you tell me more about [a particular element of an experience]?" or "Can you tell me what [a particular experience] meant to you?" This approach to probing facilitated gathering detailed data and allowed the investigators to determine saturation. Saturation became evident when informational redundancy occurred (Sandelowski, 2008, p. 875) whereby the investigators were hearing similar experiences and were not hearing participants raise new topics. The interviews lasted an average of 30–60 minutes. Following the interview, the investigators labeled each audio recording with an identification number. A professional transcriptionist transcribed the data verbatim. During the transcription process, identifying information was removed. The data were further deidentified during the data analysis by replacing participant names with pseudonyms.

Data Analysis

The investigators analyzed the data using Benner (1985, 1994) and Diekelmann and Ironside's (1998) approaches to phenomenological and hermeneutical data analysis. They began the data analysis by reading each transcript

numerous times. This repeated reading of the transcripts permitted a comprehensive understanding of the data (Benner, 1994). They then coded the data by excerpting exemplars, which were strong instances of participants' experiences of caring for suicidal persons (Benner, 1994). They reread the exemplars, placing those with commonalities into categories. They continued analyzing the data by rereading exemplars within each category. They wrote interpretations of exemplars to disclose the meanings of participants' experiences (Benner, 1985), shared their interpretations with one another, and agreed on those interpretations that best explicated meanings of participants' experiences of caring for suicidal persons. To augment understandings of the data, they integrated relevant literature into their interpretations (Diekelmann & Ironside, 1998). They concluded the interpretive process by developing themes that captured salient insights emerging from the data analysis.

Rigor

The investigators maintained rigor by adhering to Madison's (1988) principles for evaluating interpretive research. Madison developed these principles from Gadamer's philosophical works. He contended that the principles are similar to ethical norms whereby the investigator(s) uses them to maintain "good judgment" when interpreting texts (p. 30). The principles included appropriateness, coherence, comprehensiveness, agreement, suggestiveness, and potential. They ensured appropriateness by adhering to an unstructured interview process, allowing participants to describe any experience of caring for suicidal persons. They achieved coherence and comprehensiveness by excerpting exemplars that best described participants' experiences of caring for suicidal persons. In adhering to agreement, they ensured the interpretations reflected participants' accounts of suicide care. They used suggestiveness to identify educational implications for teaching students about caring for suicidal persons and for delineating future research needs. Potential included an assumption that there are multiple interpretations of participant experiences, but interpretations must be warranted.

Findings

Three themes emerged from the data analysis. Each theme presents a distinct but important understanding of participants' experiences of caring for suicidal persons.

Theme 1: Reading Charts: Fearing, Disrupting, and Altering Views of Suicidal Persons

As many participants described assessing patients for suicidal ideation, they related that reading about the patient's mental status and behavior in patient records initially contributed to fears about interacting with them. These fears disrupted their perceived ability to provide nursing care. Sheila said she was "apprehensive" about using empathy with her patient when she read that her patient heard voices, suggesting suicide. Jamie said she felt "nervous" about establishing rapport with her patient after reading that her patient "struck out at someone" at his residence. Once these and other participants interacted with their patients, however, they learned that "vividly expressed" documented (Laitinen, Kaunonen, & Åstedt-Kurki, 2010, p. 489) manifestations of patients' mental health problems offered just one view of them (Irving et al., 2006, p. 153). Interacting with these patients altered their views of them. Selene, assigned to care for an adolescent who threatened to harm himself and a family member, explained further:

> Reading from his chart, he was very angry and aggressive toward a [family member] who didn't feel safe being alone with him. I was nervous to be his nurse and to be asking him those questions [about suicidal ideation] and doing [suicide] assessments on him. When I first met him, he was just a regular person. He talked about school and college. He gave me all of these goals he wanted in his life. He [said] he was pretty angry and he wanted to work on his relationship with his [family member].

Selene reflected on how patient documentation created an image of a violent patient, which initially made her nervous about completing a suicide assessment. Consequently, she feared asking him questions to assess suicide risk, worrying that the questions would provoke the patient's anger or aggression. Once she met the patient, she learned he was not the patient portrayed in the chart; he was a "regular person" who had a lot to share with her, including his future goals, aspirations, and desires to have a healthy relationship with his family member.

Despite the number of participants who were initially frightened by patient documentation, a few participants were able to hold this documentation open and problematic (Andrews et al., 2001). These participants demonstrated what Binding and Tapp (2008) identified as "openness to the other's position" (p. 125) where they were open to the patient's story and perspective, recognizing patient documentation often excluded the voice of the patient. For instance, Jada said she learned about her patient through reading the chart, but she "wanted to hear the patient's story about how he got into the mental health unit." Similarly, Allison conveyed, that although she read what was in the chart, she "wanted to hear it from him 'specifically'" so she could "gain an understanding from his perspective." Wendy related that the chart provided information about the patient, but she held this information in abeyance by questioning, "This is what the chart says, but is that [the patient's behavior] really it?" These participants' "openness to the other's position" (Binding & Tapp, 2008, p. 125) meant they were merging the patient's point of view with the information in the chart to generate new points of view (Diekelmann, 2005, p. 23). These new viewpoints tempered the authority of the chart, creating spaces for these participants to genuinely listen to patients' perspectives about their suicidal tendencies.

Theme 2: Talking Versus Silence and Suicide Risk Assessments

When describing their experiences of assessing suicidal ideation, some participants remarked suicide was a "taboo" topic, and hence, it would be difficult asking patients about suicidal ideation. These participants quickly learned, however, that many patients were talkative, easily opening up to them about their suicidal tendencies. In these cases, participants' comfort in talking with patients increased as they began to understand that talking was a "centerpiece" of initiating care for suicidal persons (Cutcliffe & Stevenson, 2008, p. 950). Participants conveyed that patients who freely discussed their suicidal ideations and/or attempted suicide did not need formal suicide assessments. Rather, they "assessed" suicide risk informally through the fundamental interpersonal processes of listening to and hearing patients' experiences (Cutcliff & Barker, 2002). For instance, Chelsea said, "It is true; talking is important because sometimes you can just sit down and have a conversation and complete your entire assessment without having to go into the room and say, 'Now I am going to assess you.'" Meredith said that her patient "led the conversation," telling her everything about his experience with an overdose. Tracie related that her patient "poured her life story out" about overdosing, leaving little for her to ask when completing a suicide assessment. Similarly, Jennifer described how, through listening to her patient's "thorough" disclosure of an attempted suicide, she only needed to verify past and current suicidal ideation. She said:

> He had overdosed. I came to talk with him and he felt he needed to tell me his whole story, and he explained the [suicide] attempt thoroughly. He said, 'Now that I've been in here and I've been talking with my psychiatrist, and he established a diagnosis that seems to fit, I feel a lot more comfortable. I feel like I don't have those thoughts anymore.' I was able to reinforce, 'So you haven't had any [suicidal thoughts] since you've been here or you are not having any today?'

Not all participants described being able to assess suicide risk by listening to and hearing patients talk about their suicidal tendencies. A few participants reported times when patients were less forthcoming or silent about their suicidal tendencies. In these cases, participants remained uncomfortable with patient interactions, often not knowing what to do or say next. These withdrawn patients have been described by nurses as "screened-off" (Carlén & Bengtsson, 2007, p. 261) or not communicative about their suicidal ideations. Adrian, for example, stated that one of her patients was very "introverted" and it was "like pulling teeth" trying to talk with him. She also discussed another patient where she said she had to be "bold" in directly asking her about depression. She said this patient provided "very short responses" to her assessment questions. Likewise, Samantha described her experience of assessing suicidal ideation with a patient who was unwilling to talk with her about an attempted suicide.

> I asked her how she was feeling that day and she said, 'Fine.' I asked if she felt better than when she came in and she said, 'Yes.' Then I said, 'I know when you came you were not feeling very good about yourself and you took the bottle of pills. Are you having any of those feelings now?' She said, 'No.' Then I made sure I was right because I didn't know if she [understood I was asking about] being suicidal or not, so I said to her, 'Are you having any thoughts of suicide?' She said, 'No.' She was one that was really hard to get anything out of.

Although Samantha made attempts to elicit information about the patient's current mental status, she described how the patient disclosed little information to her. Fearing she would not complete an adequate suicide risk assessment, she ensured that the patient understood she was indeed asking her about suicidal ideation. The patient confirmed the absence of suicidal ideation. However, she recognized her assessment was hindered by the patient's limited responses to her questions. Samantha's experiences, along with those related above, were frustrating for participants because they precluded them breaking into and opening up the inner dialogue of patients (Talseth, Gilje, & Norberg, 2003) so that they could gather substantive information needed to care for suicidal persons.

Theme 3: Acting for the Good of the Patient to Meet Suicidal Persons' Needs

As participants interacted with suicidal persons, some of them identified and used nursing interventions that were relational, thoughtful, and contributed to strengthening patients' coping mechanisms (Benner, 2000; Talseth & Gilje, 2011; Tee et al., 2007). In these cases, participants used their psychiatric/mental health and general nursing knowledge to act for the good of the patient to meet their needs (Polkinghorne, 2004). Sandra said that "communication" was essential to revealing what suicidal persons needed. Similarly, Elizabeth related that it was important to simply "keep the patient talking" with health care professionals. Upon recognizing a patient's deep belief in God, Justine said that her patient's strong "faith background" helped her understand the need to incorporate spirituality into her nursing care. A few participants skillfully met the needs of suicidal persons by using nursing interventions that contributed to suicide prevention while also assessing suicide risk. Sadie explained:

> When I was asking him if he was having thoughts of suicide, he said, 'No'. I wanted to make sure. I know in class we talked about finding out what they value—family, a job and things like that. What's important to them that they're living for? He had a lot of things in his life that were a priority to him. I gained more information so I felt comfortable in saying he wasn't having those [suicidal] thoughts.

Not all participants in this study identified and provided nursing interventions that met patients' needs. Some did not provide relational, thoughtful, and supportive interventions necessary to act for the good of the patient. Kelly described caring for a patient who attempted suicide over losing a beloved pet. Rather than exploring with the patient grief and loss, she quickly surmised he was lonely and suggested that he get involved in "winter activities" such as "bowling with friends." Joanna thought she was providing a therapeutic nursing intervention by offering her patient a helpful community resource. The patient later learned he could not use the resource because he was not a resident of the city where he was hospitalized. He consequentially became discouraged and said to Joanna that, "I just need to get out of here and finish what I started." Instead of exploring and immediately addressing his suicidal gesture in more depth, she focused on wanting to know why the resource she recommended was restricted to city residents.

Hannah described one of the most noteworthy cases of a nontherapeutic intervention when she suggested that her patient's suicide attempt was "selfish" because she thought the patient was not considering the effect his suicide would have on his family. Her understanding of suicide as a selfish act resonates with the stigmatization of those with mental health problems (Thornicraft, 2008), which strongly shaped her view of the suicide prevention care she thought he needed (Hamilton & Manias, 2006). She said:

> I wanted to bring him out of the secure unit and get him a little bit more involved. Hopefully, allow us to talk to his family and allow us to get that connection back with his children. He was selfish…and I felt advocating and bringing him out would really benefit him.

Hannah thwarted the appropriate use of advocacy as a therapeutic nursing intervention through taking a paternalistic approach to it. Her reference to "I wanted" and "allow us" was nurse-centered and promoted "structured engagement of care" by directing goal setting for the patient without thoughtful, deliberative, collaborative care planning (MacNeela et al., 2012, p. 1302). This approach to nursing care could increase the patient's potential for experiencing ongoing psychache or the "hurt, anguish, soreness, aching, psychological pain in the mind" of suicidal persons (Shneidman, 1993, p. 51).

Discussion

Findings of this study indicate that, when participants read documentation about suicidal persons' mental status and behavior, they experienced initial fears about interacting with them. These fears disrupted their perceived ability to provide nursing care for suicidal persons. These findings closely align with a plethora of literature indicating that nursing students commonly fear those with mental health problems and that these fears can impede their ability to care for these individuals (Ewashen & Lane, 2007; Fisher, 2002; Happell & Gough, 2009). The findings also suggest, however, that participants overcame fears generated from reading the documentation of suicidal persons by interacting with them and understanding that they were simply people (Anthony, 2004). This finding is also consistent with previous research, which suggests that students' interactions with patients in mental health settings decreases their fears and increases their positive attitudes toward those with mental health problems (Buxton, 2011; Happell, Robins, & Gough, 2008; Mullen & Murray, 2002). Most significant, however, is the finding indicating how a few participants suspended judgment about the information they read in the charts of suicidal persons until they interacted with them. There is little research about students who report having open and positive attitudes about caring for suicidal persons prior to interacting with them and how these attitudes influence their nursing care.

The findings of this study also demonstrated that the participants' abilities to gather information necessary to complete suicide risk assessments was impacted by how much patients talked to them about their suicidal tendencies. When patients disclosed little information about suicidal thoughts or intents, some participants felt there was little they could do except ask them to verify or deny suicidal ideation. Conversely, when participants reported patients were talkative about their suicidal tendencies, some surmised they did not need to conduct a formal suicide risk assessment. Listening to and hearing patients freely talk about their suicidal tendencies did facilitate their suicide risk assessment. However, this finding should be viewed with caution, particularly in light of Benner's (1984) hallmark research about novice nurses' needs for experiences to practice nursing competently. In fact, Billings (2004) noted that caring for suicidal persons is akin to caring for intensive care patients and, further, that care of suicidal persons requires careful and complete assessments where nurses can discover clues about suicide risk (Billings, 2003, p. 176). Even the most experienced nurses are not conducting comprehensive suicide risk assessments to detect these clues (Aflague & Ferszt, 2010), which means novice nurses are likely limited by their ability to conduct accurate and thorough suicide risk assessments.

Also evident in this study was the tenuous nature of providing interventions for those at risk for suicide. Participants who provided nursing interventions that were thoughtful and relational were acting for the good of the patient; their interventions held great therapeutic value for suicidal persons. For instance, the participant who recognized a patient's strong belief in God was mindful of the need to incorporate spirituality into her care. On the other hand, participants whose interventions were not as thoughtful, relational, and supportive in meeting the patient's needs may have put the patient at more risk for harm than good. For example, the participant who recommended an unrealistic community

Table 1. Teaching Strategies That Align With Themes

Theme	Strategy
Theme 1: Reading charts: Fearing, disrupting, and altering views of suicidal persons	Remind students about the importance of documenting suicidal person's status, needs, and progress. Acknowledge and discuss with students fears about reading records of suicidal persons. Ask students to read, respond to, critique, discuss, and reflect on case examples of the documented care of suicidal persons.
Theme 2: Talking versus silence and suicide risk assessments	Instruct students to use suicide risk assessment tools and evidence-based interviewing approaches with talkative and withdrawn patients. Ensure students communicate with clinical instructors and the health care team suicide risk assessment findings.
Theme 3: Acting for the good of the patient to meet suicidal persons' needs	Ask students to use evidence-based interventions for those at risk for suicide. Ask students to consult with their clinical instructor and the health care team when making decisions about interventions for suicidal persons. Use literature about developing thinking in mental health clinicians to devise approaches to teach students critical thinking in the care of suicidal persons. Use case studies, simulations, and reflections to develop students' clinical judgment about suicide prevention interventions.

resource for her patient may have inadvertently exacerbated the patient's suicide risk. That is, this patient was so disappointed in learning he could not use the resource that he conveyed to the participant a return of suicidal ideation—an ideation the participant did not further explore. The dichotomy between those participants providing therapeutic nursing interventions versus those providing less-than-optimal nursing interventions stresses the criticality of ensuring that students are using good critical thinking skills and its variants (i.e., clinical judgment, clinical decision making, etc.) in caring for suicidal persons. There are studies about developing thinking in mental health clinicians (Crook, 2001; MacNeela et al., 2010; Muir-Cochrane et al., 2011); however, there is little literature about improving students' thinking specifically in caring for suicidal persons.

Educational Implications

The study themes provide understandings about nursing students' care of suicidal persons. Educational implications that align with these themes are summarized in Table 1. In regard to patient documentation, nurse educators need to remind students that documentation facilitates communication about a suicidal person's status, needs, and progress. Nonetheless, they need to acknowledge and discuss with students the fear they can experience when reading records of suicidal persons and how this fear can disrupt perceptions of providing nursing care. To challenge and alleviate their fears, teachers can ask students to read, respond to, critique, and discuss case examples of the documented care of suicidal persons. This activity can promote reflection about how documentation can exclude patients' voices and influence caring for suicidal persons. In regard to suicide risk assessments, teachers need to ensure that students use reliable and valid suicide risk assessment tools and evidence-based approaches to interviewing both talkative and withdrawn suicidal persons. They need to share findings from these formal assessments with their clinical instructor and the health care team, which will allow experienced clinicians to ensure that students have completed an accurate and thorough suicide risk assessment. In relationship to critical thinking, students can reference textbooks, practice guidelines, and other relevant resources for evidence-based interventions to use with those at risk for suicide. Yet, it is important for students to consult with their clinical instructor and the health care team to ensure that their interventions are patient centered. Clinically based literature about developing thinking in mental health clinicians and case studies, simulations, and reflective activities that focus on developing clinical judgment can also be useful in teaching safe and quality interventions for suicidal persons.

Limitations and Future Research

A limitation of this study was that it was a single site, qualitative study with a homogenous sample. The study design limited the investigator's abilities to quantify how students' completion of the mental health course influenced their care of suicidal persons. In addition, the open-ended interview limited asking specific questions about how other sources of students' experiences (e.g., students' personal experiences of suicide within their own family, their perceptions of suicide, etc.) may have influenced the data obtained. Nonetheless, the findings of this study underscore future research needs. Importantly, the findings indicate a need for investigating attitudes of students who report being nonjudgmental about suicide care despite the documented manifestations of this mental health problem. This research could result in greater knowledge about teaching students the characteristics required to promote open and positive attitudes to caring for suicidal persons prior to interacting with them. Study findings also indicate a need to

investigate students' abilities to conduct suicide risk assessments using reliable and valid suicide risk assessment tools and evidence-based interviewing protocols. This research could lend itself to learning more about how to develop students' clinical judgments about what constitutes an accurate and thorough suicide risk assessment. In addition, findings suggest that research is needed to identify educational interventions that ensure students learn and use appropriate critical thinking skills when providing interventions for suicidal persons. Drawing on study designs used in research aimed at developing thinking in mental health clinicians would provide a useful starting point for such studies in nursing education.

Conclusion

Nurses interact with suicidal persons on a regular basis in various health care settings. Their reports about lacking competencies in caring for suicidal persons raise serious concerns that highlight the imperative need to address the preparation of nursing students in caring for this population of patients. This study provides a step toward understanding pedagogies that can improve how nursing students learn to care for suicidal persons across health care settings in ways that contribute to their desire to live rather than die.

Acknowledgments

The authors wish to thank Viterbo University for funding this study. They also wish to thank Elizabeth Harrison and Jennifer Hedrick-Erickson for their thoughtful review of this article.

References

Aflague, J. M., & Ferszt, G. G. (2010). Suicide assessment by psychiatric nurses: A phenomenologic study. *Issues in Mental Health Nursing*, *31*, 248–256, http://dx.doi.org/10.3109/01612840903267612.

Andrews, C. A., Ironside, P. M., Nosek, C., Sims, S. L., Swenson, M. M., Yeomans, C., et al (2001). Enacting narrative pedagogy: The lived experiences of students and teachers. *Nursing Health Care Perspectives*, *22*, 252–259.

Anthony, W. A. (2004). The principle of personhood: The field's transcendent principle. *Psychiatric Rehabilitation Journal*, *27*, 205, http://dx.doi.org/10.2975/27.2004.205.205.

Benner, P. (1984). *From novice to expert: Excellence and power in clinical nursing practice*. Menlo Park, CA: Addison-Wesley Publishing Company.

Benner, P. (1985). Quality of life: A phenomenological perspective on explanation, prediction, and understanding in nursing science. *Advances in Nursing Science*, *8*, 1–14.

P. Benner (Ed.). (1994). Interpretive phenomenology: Embodiment, caring, and ethics in health and illness. (pp. 99–127). Thousand Oaks, CA: Sage Publications.

Benner, P. (2000). The roles of embodiment, emotion and lifeworld for rationality and agency in nursing practice. *Nursing Philosophy*, *1*, 5–19.

Bertolote, J. M., & Fleischmann, A. (2009). *A global perspective on the magnitude of suicide mortality*. In D. Wassermann C Wasserman (Eds.). *Oxford textbook of suicidology and suicide prevention: A global perspective*. (pp. 91–98). Oxford, OX: Oxford University Press.

Billings, C. V. (2003). Psychiatric inpatient suicide: Assessment strategies. *Journal of the American Psychiatric Nurses Association*, *9*, 176–178.

Billings, C. V. (2004). Psychiatric inpatient suicide: Focus on intervention. *Journal of the American Psychiatric Nurses Association*, *10*, 190–192, http://dx.doi.org/10.1177/1078390304267429.

Binding, L., & Tapp, D. M. (2008). Human understanding in dialogue: Gadamer's recovery of the genuine. *Nursing Philosophy*, *9*, 121–130.

Buxton, B. K. (2011). Interaction, unscripted. *Journal of Psychosocial Nursing and Mental Health Services*, *49*, 28–32, http://dx.doi.org/10.3928/02793695-20110329-03.

Caputo, J. D. (1987). *Radical hermeneutics: Repetition, deconstruction, and the hermeneutic project*. Bloomington and Indianapolis: Indiana University Press.

Carlén, P., & Bengtsson, A. (2007). Suicidal patients as experienced by psychiatric nurses in inpatient care. *International Journal of Mental Health Nursing*, *16*, 257–265, http://dx.doi.org/10.1111/j.1447-0349.2007.00475.x.

Centers for Disease Control and Prevention. (2012). Suicide facts at a glance. Retrieved from http://www.cdc.gov/violenceprevention/pdf/Suicide-DataSheet-a.pdf2012.

Crook, J. A. (2001). How do expert mental health nurses make on-the-spot clinical decisions? A review of the literature. *Journal of Psychiatric and Mental Health Nursing*, *8*, 1–5.

Cutcliff, J. R., & Barker, P. (2002). Considering the care of the suicidal client and the case for 'engagement and inspiring hope' or 'observations'. *Journal of Psychiatric and Mental Health Nursing*, *9*, 611–621.

Cutcliffe, J. R., & Stevenson, C. (2008). Feeling our way in the dark: The psychiatric nursing care of suicidal people—A literature review. *International Journal of Nursing Studies*, *45*, 942–953, http://dx.doi.org/10.1016/j.ijnurstu.2007.02.002.

Dickerson-Swift, V., James, E. L., Kippen, S., & Liamputtong, P (2007). Doing sensitive research: What challenges to qualitative researchers face? *Qualitative Research*, *7*, 327–353, http://dx.doi.org/10.1177/1468794107078515.

Diekelmann, J. (2005). *The retrieval of method: The method of retrieval*. In P. M. Ironside (Ed.). *Beyond method: Philosophical conversations in healthcare research and scholarship*. (pp. 3–57). Madison, WI: The University of Wisconsin Press.

Diekelmann, N., & Ironside, P. (1998). *Hermeneutics*. In J Fitzpatrick (Ed.). *Encyclopedia of nursing research*. (pp. 243–245). New York, NY: Springer.

Ewashen, C., & Lane, A. (2007). Pedagogy, power and practice ethics: Clinical teaching in psychiatric mental health settings. *Nursing Inquiry*, *14*, 255–262.

Feldman, M., Frank, P., Duberstein, P., Vannoy, S., Epstein, R., & Kravite, R. (2009). Let's not talk about it: Suicide inquiry in primary care. *Annals of Family Medicine*, *5*, 412–418.

Fisher, J. E. (2002). Fear and learning in mental health settings. *International Journal of Mental Health Nursing*, *11*, 128–134, http://dx.doi.org/10.1046/j.1440-0979.2002.t01-1-00205.x.

Fontanna, A., & Frey, J. H. (2008). *The interview: From neutral stance to political involvement*. In N. K. DenzinY. S. Lincoln (Eds.). *Collecting and interpreting qualitative materials*. (pp. 115–159). Los Angeles, CA: Sage Publications.

Gadamer HG. (1989). Truth and method (J. Weinsheimer & D.G. Marshall, Trans.). New York, NY: Continuum. (Original work published 1960).

Hamilton, B., & Manias, E. (2006). 'She's manipulative and he's right off': A critical analysis of psychiatric nurses' oral and written language in the acute inpatient setting. *International Journal of Mental Health Nursing*, *15*, 84–92, http://dx.doi.org/10.1111/j.1447-0349.2006.00407.x.

Happell, B., & Gough, K. (2009). Nursing students' attitudes to mental health nursing: Psychometric properties of a self-report scale. *Archives of Psychiatric Nursing*, *23*, 376–386, http://dx.doi.org/10.1016/j.apnu.2008.10.005.

Happell, B., Robins, A., & Gough, K. (2008). Developing more positive attitudes towards mental health nursing in undergraduate nursing students: Part 1—does more theory help? *Journal of Psychiatric and Mental Health Nursing*, *15*, 439–446, http://dx.doi.org/10.1111/j.1365-2850.2007.01203.x.

Hazell, P., Hazell, T., Waring, T., & Sly, K. (1999). A survey of suicide prevention curricula taught in Australian universities. *Australian and New Zealand Journal of Psychiatry*, *33*, 253–259.

Heidegger, M. (1962). Being and time (J.M.E. Robinson, Trans.). New York, NY: HarperCollins. (Original work published 1927).

International Society of Psychiatric-Mental Health Nurses & American Psychiatric Nurses Association. (2008). Essentials of psychiatric mental health nursing in the BSN curriculum. Retrieved from http://www.ispn-psych.org/docs/08CurricularGuidesUndergrad.pdf2008.

Irving, K., Treacy, M., Scott, A., Hyde, A., Butler, M., & MacNeela, P. (2006). Discursive practices in the documentation of patient assessments. *Journal of Advanced Nursing*, *53*, 151–159.

Kawanishi, C., Sato, R., Yamada, T., Ikeda, H., Suda, A., & Hirayasu, Y. (2006). Knowledge and attitudes of nurses, nursing students and psychiatric social workers concerning current suicide-related issues in Japan. *Primary Care Mental Health*, *4*, 285–292.

Keogh, B., Doyle, L., & Morrissey, J. (2007). Suicidal behaviour. A study of emergency nurses' educational needs when caring for this patient group. *Emergency Nursing*, *15*, 30–35.

Laitinen, H., Kaunonen, M., & Åstedt-Kurki, P. (2010). Patient-focused nursing documentation expressed by nurses. *Journal of Clinical Nursing*, *19*, 489–497, http://dx.doi.org/10.1111/j.1365-2702.2009.02983.x.

MacNeela, P., Clinton, G., Place, C., Scott, A., Treacy, P., Hyde, A, et al (2010). Psychosocial care in mental health nursing: A think aloud study. *Journal of Advanced Nursing*, *66*, 1297–1307, http://dx.doi.org/10.1111/j.1365-2648.2009.05245.x.

Madison, G. B. (1988). *Method in interpretation. In the hermeneutics of postmodernity: Figures and themes*. Bloomington, IN: Indiana University Press.

Moules, N. (2001). Hermeneutic inquiry: Paying heed to history and hermes an ancestral, substantive methodological tale. *International Journal of Qualitative Methods*, *1*, 1–21.

Muir-Cochrane, E., Gerace, A., Mosel, K., O'Kane, D., Barkway, P., Curren, D., et al (2011). Managing risk: Clinical decision-making in mental health services. *Issues in Mental Health Nursing*, *32*, 726–734, http://dx.doi.org/10.3109/01612840.2011.603880.

Mullen, A., & Murray, L. (2002). Clinical placements in mental health: Are clinicians doing enough for undergraduate nursing students? *International Journal of Mental Health Nursing*, *11*, 61–68, http://dx.doi.org/10.1046/j.1440-0979.2002.00227.x.

Nock, M. K., Hwang, I., Sampson, N., Kessler, R. C., Angermeyer, M., Beautrais, A., et al (2009). Cross-national analysis of the associations among mental disorders and suicidal behavior: Findings from the WHO World Mental Health Surveys. *PLoS Medicine*, *6*, e1000123.

Oravecz, R., & Moore, M. M. (2006). Recognition of suicide risk according to the characteristics of the suicide process. *Death Studies*, *30*, 269–279.

Palmer, R. E. (1969). *Hermeneutics*. Evanston, IL: Northwestern University Press.

Pederson, C. (1993). Promoting nursing students' positive attitudes toward providing care for suicidal patients. *Issues in Mental Health Nursing*, *14*, 67–84.

Polkinghorne, D. (2004). *Practice and the human sciences: The case for a judgment-based practice of care*. Albany, NY: State University of New York Press.

Robinson-Smith, G., Bradley, P. K., & Meakim, C. (2009). Evaluating the use of standardized patients in undergraduate psychiatric nursing experiences. *Clinical Simulation in Nursing*, *5*, e203–e211, http://dx.doi.org/10.1016/j.ecns.2009.07.001.

Sandelowski, M. (1995). Focus on qualitative methods. Sample size in qualitative research. *Research in Nursing & Health*, *18*, 179–183.

Sandelowski, M. (1996). Focus on qualitative methods. One is the liveliest number: The case orientation of qualitative research. *Research in Nursing & Health*, *19*, 525–529.

Sandelowski, M. (2008). *Theoretical saturation*. In L. M. Given (Ed.). *The Sage encyclopedia of qualitative research methods*, Vol. 2. Thousand Oaks, CA: Sage.

Shneidman, E. (1993). *Suicide as psychache. A clinical approach to self-destructive behavior*. Northvale, NJ: Jason Aronson, Inc.

Stuart, G. (2013). *Principles and practice of psychiatric nursing* (10th ed.). St. Louis, MO: Mosby.

Sun, F. K., Long, A., Boore, J., & Tsao, L. (2006). A theory for the nursing care of patients at risk for suicide. *Journal of Advanced Nursing*, *53*, 680–690.

Sun, F. K., Long, A., Huang, X. Y., & Chiang, C. Y. (2011). A quasi-experimental investigation into the efficacy of a suicide education programme for second-year nurses in Taiwan. *Journal of Clinical Nursing*, *20*, 837–846, http://dx.doi.org/10.1111/j.1365-2702.2010.03503.x.

Talseth, A. G., & Gilje, F. L. (2011). Nurses' responses to suicide and suicidal patients: A critical interpretive synthesis. *Journal of Clinical Nursing*, *20*, 1651–1667, http://dx.doi.org/10.1111/j.1365-2702.2010,03490.x.

Talseth, A.G., Gilje, F., & Norberg, A. (2003). Struggling to become ready for consolation: Experiences of suicidal patients. Nursing Ethics, 10, 614–623. doi 101191/0969733003ne6510a.

Tee, S., Lathlean, J., Herbert, L., Coldham, T., East, B., & Johnson, T. J. (2007). User participation in mental health nurse decision-making: A co-operative enquiry. *Journal of Advanced Nursing*, *60*, 135–145, http://dx.doi.org/10.1111/j.1365-2648.2007.04345.x.

The Joint Commission. (2013). Behavioral health care: 2013 National patient safety goals. Retrieved from http://www.jointcommission.org/standards_information/npsgs.aspx.

Thornicraft, G. (2008). Stigma and discrimination limit access to mental health care. *Epidemiology and Psychiatric Sciences*, *17*, 14–19, http://dx.doi.org/10.1017/S1121189X00002621.

U.S. Department of Health and Human Services. (2013). Healthy people 2020. Retrieved from http://www.healthypeople.gov/2020/default.aspx.

U.S. Department of Health and Human Services Office of the Surgeon General and National Action Alliance for Suicide Prevention. (2012). 2012 National strategy for suicide prevention: Goals and objectives for action. Retrieved from

http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/.

Valente, S. (2002). Overcoming barriers to suicide risk management. *Journal of Psychosocial Nursing & Mental Health Services*, *40*, 22–32.

Valente, S., & Saunders, J. M. (2004). Barriers to suicide risk management in clinical practice: A national survey of oncology nurses. *Issues in Mental Health Nursing*, *25*, 629–648, http://dx.doi.org/10.1080/01612840490472147.

Welton, R. S. (2007). The management of suicidality: Assessment and intervention. *Psychiatry*, *4*, 24–34.

World Health Organization. (2012). Suicide prevention. Retrieved from http://www.who.int/mental_health/prevention/en/.