

## What can qualitative research tell us about helping a person who is suicidal?

Nurses may encounter people who experience suicidal thoughts. A systematic review was undertaken to identify themes that can inform empathic care

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This review of qualitative research on how people live with or recover from being suicidal focuses particularly on the implications for nurses in a range of practice settings.

Most research on suicide has been undertaken with the aim of identifying groups at risk.

Qualitative research can help in understanding the experience of individuals who are suicidal and those who are recovering. While methods, sample groups and research questions have varied, some consistent findings serve to highlight the pain, suffering and alienation associated with the suicidal crisis. Qualitative research also reveals the potential for nurses to make an important, even life saving difference through the way in which they relate to people who are suicidal.

### BACKGROUND

Nurses in almost all areas of practice are likely to encounter people who attempt, complete or think about suicide. It is a leading cause of death among young people in many countries and it is estimated that more than one million people around the world take their own life every year (Anderson and Jenkins, 2005).

In the UK from 1991 suicide rates fell across all age groups, until a peak in 2008 when 5,706 people were reported to have completed suicide (Office for National Statistics, 2010). Despite the gravity, human tragedy and grief reflected in these statistics, completed suicide is a relatively rare event (more than half a million people died in the UK in 2008). On the other hand, attempted suicide, self harm and suicidal thoughts are common. It is estimated that a GP in the UK may see more than 100 people a year who report suicidal thoughts but no more than one person every four years who completes suicide (Booth and Owens, 2000). Nurses, too, may expect to see many people who experience suicidal thoughts and may be at risk of completing suicide.

In the general population, suicidal thoughts are common. It is estimated that, at any given time, 15-25% of adolescents have thought about suicide (Bridge et al, 2006). In people with acute depression, the experience of suicidal thoughts is 60-70%, and rates of suicide completion in people with chronic depression may be above 10% (Moller, 2003).

Many health problems are associated with depression and an increased risk of suicide. For example, a cancer diagnosis has been found to at least double the risk of completed suicide (Misono et al, 2008) and an HIV diagnosis in some populations has been found to elevate the risk of suicide to some 20-36 times higher than that in the general population (Meel and Leenaars, 2005). Recent reviews have also suggested there is an association between suicidal behaviour and cardiac risk factors (Placido and Sposito, 2009).

### PRACTICE POINTS

- The evidence base addressing how to help people who are suicidal is sparse because of the difficulties of involving this group in research.
- Qualitative research has looked at the experience of being suicidal, the depth of people's suffering, the nature of their struggles and how they recover a will to live.
- People who have been suicidal in the past frequently identify moments, events or encounters with people that they consider were pivotal to their recovery.
- Nurses in almost any setting are likely to encounter people who are suicidal; the way they engage with them, respond to their distress and contain it, and communicate hope can have a decisive impact on wellbeing.

### Evidence base

Considerable research efforts to date have focused on identifying risk and protective factors for suicide. In particular, attention has been given to uncovering the underlying pathology or predisposing genetic, psychological and biological factors within individuals, and patterns of suicidal behaviour in populations.

Assessment of suicide risk is a critical nursing task (Cutcliffe and Barker, 2004) and perceived imminent suicide risk is a common reason for psychiatric hospitalisation (Cochrane-Brink et al, 2000). Yet no clinical intervention has a strong evidence base for preventing suicide. This is partly because of the relative rarity of completed suicide and the ethical as well as pragmatic problems of doing research with people who are suicidal (Lakeman and Fitzgerald, 2009).

There is also little research looking at the resolution of the suicidal crisis or the interventions that help people recover. The majority of people do recover and it appears that the kind of care nurses provide may be pivotal in helping people resolve the suicidal crisis (Samuelsson et al, 2000).

In order to draw attention to and consider

the experiences of people who are suicidal, we undertook a systematic review of qualitative research published between 1997 and 2007 examining how people live with or recover from suicidal ideation (Lakeman and FitzGerald, 2008). Of the 1,130 references found, only 12 studies met all inclusion criteria.

Bergmans et al (2009) published a grounded theory study on the recovery of young adults from repeated suicide behaviour, which had remarkably similar findings to those in our review.

This article discusses how the themes we identified can inform nursing care.

## KEY THEMES

### The experience of suffering

The person who is suicidal experiences considerable psychological pain. Everall et al (2006) explored the emotional experiences of young people who were previously suicidal and found intense and overwhelming despair, shame and self loathing, which came to pervade every element of their lives.

Siegel and Meyer (1999) found that people who had been diagnosed with HIV invoked stereotypical images of life with AIDS and responded with overwhelming terror and emotional distress. Bennett (2005) reported that people who had suffered loss of a spouse felt empty and lost, and were indifferent to living or dying.

Moore (1997) identified "psychache" as a dominant theme and suggested the narratives of older adults who were suicidal were "rendered through the eyes of deep pain and suffering".

Psychache is a term coined by the famous suicide researcher Shneidman (1996), who described it as "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 of dying badly".

People turn to suicide when psychache becomes overwhelming and unbearable.

### Struggle

The person who is suicidal is engaged in a struggle. Bennett et al (2002) provided accounts of young people's struggles to resist suicide – a struggle that, for some, appeared ongoing.

At the other end of the life span, in older adults, Crocker et al (2006) described struggle as being a central process throughout the suicidal crisis. Before a suicide attempt, there was an intensification of a struggle in coming to terms with ageing

and, in particular, maintaining control and visibility or connection with others. The suicide attempt was characterised as a struggle between giving up or being dragged down, and finding a solution. Following the suicide attempt, the older adult struggled to regain control and become more visible in positive ways.

Central to the struggle of all people who are suicidal is the quest to find meaning in some experience of life, such as living with HIV infection (Siegel and Meyer, 1999) or ageing (Moore, 1997), and also to derive meaning from the crisis itself. Cutcliffe et al (2006), in a study of how psychiatric nurses work with people who are suicidal, proposed that finding meaning in being suicidal and going on in the context of the crisis were important challenges for people and a key component of learning to live again.

For the most part in the studies reviewed, suicide was perceived as a choice and people recalled making an active decision to take their own lives or carry on (Bennett, 2005; Paproski, 1997). Paradoxically, making the decision to carry on or to commit suicide could be one of the few clear choices that people perceive they have, when control over other aspects of their lives and circumstances appears diminished.

Making a suicide attempt or choosing not to do so may be a means of taking control or may be a first step in taking control of other aspects of life. In grappling with this choice to live or die, people are forced to confront what it means to live. The suicidal crisis may, as Siegel and Meyer (1999) suggested, provoke a process of coping and a redefinition of what it might mean to live with a condition such as HIV – ultimately, this can enhance a sense of control over life. Cutcliffe et al (2006) suggested that people regained a sense of control over their thoughts and feelings as they reconnected with humanity.

### Connection

Suicidality is almost always accompanied by a sense of alienation and disconnection from others, individuals, family or God.

Some of Moore's (1997) respondents said they perceived that nobody genuinely cared for them and some could not recall ever being told they were loved. Crocker et al (2006) found that, before a suicide attempt, older adults progressively became more detached from the wider community, had a diminishing social circle and felt isolated even in the presence of others.

Feeling unneeded also provokes reflection on the purpose of living. Talseth et al

(2003) described people who are suicidal as longing for closeness and connection. Clearly, talking with others and having a sense of being understood are things that help people to strengthen their sense of connection with others.

Samuelsson et al (2000), who explored the views of people who were admitted to a psychiatric hospital after a suicide attempt, reported that almost all patients described being able to talk with staff, feeling understood by them and feeling free to access them when needed as vitally important.

Cutcliffe et al (2006) described a more nuanced process of reconnection in the context of the nurse-patient relationship. Early in the suicidal crisis, the idea of reconnecting with all former human connections is overwhelming to people and the relationship needed at that time is essentially containing. Feeling cared about, feeling that one matters as well as feeling connected could be experienced through the presence, warmth and compassion of people such as nurses.

In the early stages of the suicidal crisis, the nurse reflects an image of humanity and, through intense, warm, human contact, provides an experience that is incompatible with the desolate, alienated experience of being suicidal. This is consistent with Paulson and Everall's (2003) finding that adolescents found kindness, understanding and acceptance the most helpful aspects of being in psychotherapy.

Bostik and Everall (2007) also found that young people who have been suicidal in the past identified particular relationships that were pivotal in their recovery. These were experienced differently from other relationships they had had with others around the time of attempting suicide in that they were accepting, permanent, encouraging, supportive, intimate and close. It was the experience of being in such relationships that challenged negative self beliefs, engendered hope and enabled people to move beyond being suicidal.

Cutcliffe et al (2006) suggested that actually reconnecting with humanity is a further stage in a person's recovery, made possible by the corrective experience of feeling cared for.

The relationship with the nurse in this phase is often experienced differently from other relationships, particularly in that it feels safe, secure and non-judgemental, while also enabling negative views of the world to be challenged. In this context, the person rediscovers their own strengths, begins to reframe or look at things more positively

## BOX 1. SUPPORTING PEOPLE WHO ARE SUICIDAL

Nurses can help patients who are suicidal by:

- Listening;
- Offering understanding;
- Engaging with them rather than just observing;
- Helping them reconnect with people;
- Making them feel cared for;
- Showing compassion.

and learns or develops the tools and the capacity to reconnect with others and live again. Reconnecting with others appears important in sustaining a more hopeful outlook on life.

Bennett et al (2002) described reconnecting with friends and family, and seeking or accepting help from others as pivotal to recovery. Talseth et al (2001a; 2001b; 1999) reported people who are suicidal describing helpful nurses and doctors who listened to and trusted them, and connected in a personal way. Others have found support groups – friends as well as professionals – particularly helpful (Siegel and Meyer, 1999; Eagles et al, 2003).

Ultimately, reconnecting with family, friends and other natural supports appears to be something that is important to most people (Paproski, 1997).

### Turning points

Accounts of people resolving suicide often reveal memorable milestones or turning points marking a sudden and profound shift away from wanting to take their own life. Young people identified a change in environment such as leaving home as liberating them from negative emotional states; all could identify a pivotal relationship that made a profound difference to their wellbeing (Everall et al, 2006).

Bergmans et al's (2009) group of young people who had been suicidal in the past recalled periods of ambivalence in which they were undecided about living or dying; what helped them exit this mindset were a series of "tipping or turning points" that raised their awareness about their situation. For some, the experience of coming to terms with the death of another person helped resolve their ambivalence about living.

Bennett (2005) observed that people could identify a specific moment or event that was associated with change. For example, one widower reported that attending a concert was the "first step on the road to normality". Others recalled the moment they chose

to live and made an explicit choice to seek help (Siegel and Meyer, 1999). For some people, hospital admission and the corrective emotional experience described previously were the pivotal events that gave them insight into the value of living (Samuelsson et al, 2000). Cutcliffe and Stevenson (2007) used the term "gestalt" to describe flashes of insight or sudden understandings about the person's feelings, thoughts and situation.

Accepting help and giving voice to previously unspoken and conflicted thoughts and feelings can be associated with the re-emergence of hope. Cutcliffe et al (2006) described an overall process of reconnecting with humanity but, in some people, the experience of being cared for could engender rapid change. For example, a person was reported as saying: "They just changed my life in three days because they were so loving and kind." Siegel and Meyer (1999) suggested that the suicidal crisis, if resolved positively, can give rise to new understandings and a renewed commitment to living.

Box 1 outlines practical ways in which nurses can support people who are suicidal.

### Suicide and coping

Suicidality may be considered a failure to cope with life, a challenge to coping and also as a means to cope with intolerable emotions. Paulson and Everall (2003) described suicidal behaviour as a problem solving one, reflecting participants' way of relating to the world. Positive change was associated with extending their repertoire of coping strategies.

Siegel and Meyer (1999) suggested that suicidality provoked a process of coping with HIV and enhanced people's sense of control over life. Being suicidal allowed them to imagine their worst fears and to transcend these fears. Cutcliffe et al (2006) said that an existential crisis involved facing up to the realities of living and dying. In making sense of their suicidality, people were able to feel more connected with others. For some people, a suicide attempt was seen as a means of taking control, or a solution to an intolerable situation (Crocker et al, 2006).

Fantasies about death or choosing the time, place and method of death may reinforce to the person that they at least have some power, an option or escape, and this may make it easier to go on or to endure suffering. For others, contemplation of suicide or making a suicidal gesture or attempt, was a critical event that enabled

control to be relinquished (at least temporarily) to others. Relief, which was sometimes mixed with shame, was described by some who were admitted to inpatient psychiatric care (Samuelsson et al, 2000).

### DISCUSSION

This body of qualitative research highlights the potential for people to find meaning from their experience of being suicidal and to turn their lives around (although this potential is not always realised). The presence and response of nurses to the suicidal person can be instrumental in this process.

Qualitative research highlights the sense of alienation and pain that people who are suicidal experience. Nurses must reflect on the process of care and ensure it supports the maintenance and development of positive connections with others and/or the reconnection with natural supports.

Simply observing people is likely to be insufficient to help them resolve their suicidality. Indeed, Buchanan-Barker and Barker (2005) argued that a focus on observation may obstruct the development of genuine, interpersonal caring; they proposed that nurses need to emphasise engagement with people who are vulnerable, rather than the observation of them. They suggested the "bridge" as a metaphor of care, connecting with the vulnerable individual by crossing "the threatening waters of human distress to 'reach' the person".

This fits with Cutcliffe and Stevenson's (2007) core process of caring for the suicidal person, that is, reconnecting them with humanity. Cutcliffe and Barker (2002) had previously argued that engagement involves showing an unconditional acceptance and tolerance of the client who is suicidal, removing any sense of coercion or psychological pressure and inspiring hope. A safe physical environment is, of course, important in the care of people who are suicidal but qualitative research suggests that considerable attention also needs to be given to the interpersonal environment. Safe and compassionate care, as Sun et al (2006) noted, encompasses the provision of protection, holistic assessment and healing.

To date, research efforts on suicide have greatly helped identify which groups may be at risk but have been less fruitful in improving the understanding of individuals who are suicidal and how they can best be helped. Qualitative research may help nurses and others understand the experience of the suicidal crisis, and respond in an empathic and helpful way.

The body of work that addresses the suicidal experience is small relative to the vast literature on suicide generally; many studies are small in scale and yield results that cannot be generalised beyond the particular groups that have been sampled. Nevertheless, despite the adoption of quite different methods, some consistent findings have been generated and some useful principles of care can be derived.

#### REFERENCES

- Anderson M, Jenkins R** (2005) The challenge of suicide prevention: an overview of national strategies. *Disease Management and Health Outcomes*; 13: 245-253.
- Bennett KM** (2005) "Was life worth living?" Older widowers and their explicit discourses of the decision to live. *Mortality*; 10: 144-154.
- Bennett S et al** (2002) Young people's pathways to well-being following a suicide attempt. *International Journal of Mental Health Promotion*; 4: 25-32.
- Bergmans Y et al** (2009) The perspectives of young adults on recovery from repeated suicide-related behavior. *The Journal of Crisis Intervention and Suicide Prevention*; 30: 120-127.
- Booth N, Owens C** (2000) Silent suicide: suicide among people not in contact with mental health services. *International Review of Psychiatry*; 12: 27-30.
- Bostik KE, Everall RD** (2007) Healing from suicide: adolescent perceptions of attachment relationships. *British Journal of Guidance and Counselling*; 35: 79-96.
- Bridge JA et al** (2006) Adolescent suicide and suicidal behavior. *Journal of Child Psychology and Psychiatry*; 47: 3-4, 372-394.
- Buchanan-Barker P, Barker P** (2005) Observation: the original sin of mental health nursing? *Journal of Psychiatric and Mental Health Nursing*; 12: 541-549.
- Cochrane-Brink K et al** (2000) Clinical rating scales in suicide risk assessment. *General Hospital Psychiatry*; 22: 445-451.
- Crocker L et al** (2006) Giving up or finding a solution? The experience of attempted suicide in later life. *Aging and Mental Health*; 10: 638-647.
- Cutcliffe JR, Barker P** (2004) The Nurses' Global Assessment of Suicide Risk (NGASR): developing a tool for clinical practice. *Journal of Psychiatric Mental Health Nursing*; 11: 393-400.

#### Nursing support

Nurses often encounter people at times of great vulnerability and it is unsurprising that human connection, compassion and understanding at such times is greatly valued and can play a decisive role in helping turn people's lives around.

Cutcliffe et al (2006) provided the most comprehensive account of the processes involved in nurses helping people from

acute crisis to learning to live again in the context of acute psychiatric care. However, nurses in all specialty fields and practice settings can play an important role whenever they encounter a person who is suicidal. Nurses working with such patients should aspire to be identified as people who can turn their lives around and to develop and value the interpersonal skills that help them to engage with people who are suicidal. ●

- Cutcliffe JR, 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 JR, Stevenson C** (2007) *Care of the Suicidal Person*. Edinburgh: Churchill Livingstone.
- Cutcliffe JR et al** (2006) A modified grounded theory study of how psychiatric nurses work with suicidal people. *International Journal of Nursing Studies*; 43: 791-802.
- Eagles JM et al** (2003) Suicide prevention: a study of patients' views. *British Journal of Psychiatry*; 182: 261-265.
- Everall RD et al** (2006) Being in the safety zone: emotional experiences of suicidal adolescents and emerging adults. *Journal of Adolescent Research*; 21: 370-392.
- Lakeman R, Fitzgerald M** (2009) Ethical suicide research: a survey of researchers. *International Journal of Mental Health Nursing*; 18: 10-17.
- Lakeman R, Fitzgerald M** (2008) How people live with or get over being suicidal: a review of qualitative studies. *Journal of Advanced Nursing*; 64: 114-126.
- Meel BL, Leenaars AA** (2005) Human immunodeficiency virus (HIV) and suicide in a region of Eastern Province ("Transkei"), South Africa. *Archives of Suicide Research*; 9: 69-75.
- Misono S et al** (2008) Incidence of suicide in persons with cancer. *Journal of Clinical Oncology*; 26: 4731-4738.
- Moller HJ** (2003) Suicide, suicidality and suicide prevention in affective disorders. *Acta Psychiatrica Scandinavica, Supplementum*; 418: 73-80.
- Moore SL** (1997) A phenomenological study of meaning in life in suicidal older adults. *Archives of Psychiatric Nursing*; 11: 29-36.
- Office for National Statistics** (2010) *Suicide Rates in the United Kingdom 1991-2008*. London: ONS. [tinyurl.com/suicide-uk-08](http://tinyurl.com/suicide-uk-08)

- Paproski DL** (1997) Healing experiences of British Columbia First Nations women: moving beyond suicidal ideation and intention. *Canadian Journal of Community Mental Health*; 16: 69-89.
- Paulson BL, Everall RD** (2003) Suicidal adolescents: helpful aspects of psychotherapy. *Archives of Suicide Research*; 7: 309-321.
- Placido A, Sposito AC** (2009) Association between suicide and cardiovascular disease: time series of 27 years. *International Journal of Cardiology*; 135: 261-262.
- Samuelsson M et al** (2000) Psychiatric care as seen by the attempted suicide patient. *Journal of Advanced Nursing*; 32: 635-643.
- Shneidman ES** (1996) *The Suicidal Mind*. Oxford: Oxford University Press.
- Siegel K, Meyer IH** (1999) Hope and resilience in suicide ideation and behavior of gay and bisexual men following notification of HIV infection. *AIDS Education and Prevention*; 11: 53-64.
- Sun F et al** (2006) A theory for the nursing care of patients at risk of suicide. *Journal of Advanced Nursing*; 53: 680-690.
- Talseth A et al** (2003) Struggling to become ready for consolidation: experiences of suicidal patients. *Nursing Ethics*; 10: 614-623.
- Talseth A et al** (2001a) The meaning of suicidal psychiatric inpatients' experiences of being treated by physicians. *Journal of Advanced Nursing*; 34: 96-106.
- Talseth AG et al** (2001b) Being met – a passageway to hope for relatives of patients at risk of committing suicide: a phenomenological hermeneutic study. *Archives of Psychiatric Nursing*; 15: 249-256.
- Talseth AG et al** (1999) The meaning of suicidal psychiatric in-patients' experiences of being cared for by mental health nurses. *Journal of Advanced Nursing*; 29: 1034-1041.



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