

Original Article

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Abstract

Objectives. To describe nurses' experiences of caring for individuals who have attempted suicide in specialized palliative care and to describe if the care of these individuals changed after the suicide attempt.

Methods. A qualitative, descriptive study was conducted. Nine nurses working in specialized palliative care units were interviewed following a semi-structured interview guide. Conventional content analysis was used in the analysis process.

Results. The results are presented in 3 categories: "A suicide attempt evokes strong emotions," "Health-care efforts changed after the suicide attempt," and "Experiences for the rest of working life." Suicide attempts aroused emotions in nurses such as frustration, compassion, and feelings of being manipulated. The relationship between the nurse and the individual was strengthened after the suicide attempt, and their conversations became deeper and changed in nature. Health-care efforts relating to the individual increased after the suicide attempt.

Significance of results. The results of the study can create an awareness that the palliative process also includes the risk of suicide and can be used to create conditions for nurses to be able to handle questions about suicide without fear. The results of the study can be used as an "eye opener" to the fact that suicidality occurs in palliative care. In summary, there is a critical need for nursing education in suicide risk assessment and continued follow-up care for patients at risk of suicide within palliative care.

Introduction

Suicidality is a worldwide health problem and is among the 20 leading causes of death. Every year, approximately 700,000 individuals die by suicide around the world and many more individuals attempt suicide (World Health Organization WHO 2021). Suicidal ideation is common among older adults (Zhu et al. 2022), and suicide attempts occur in palliative care (Grzybowska and Finlay 1997). Although research in this area is limited (Choy 2017; Granek et al. 2017; Marks and Drew 2012; Mayland and Mason 2004; Washington et al. 2016), previous studies have shown that patients within palliative care fluctuate on a continuum between wanting to live and actively wanting to die, depending on the degree of suffering in connection with their physical illness (Granek et al. 2017). High age, psychiatric co-morbidity, male gender, diagnoses such as AIDS or cancer, and advanced pain are risk factors for suicide (Marks and Drew 2012). Further, social and existential questions, hopelessness, and demoralization are factors that can lead to a desire for hastened death with an increased risk of suicide attempts in palliative care (Choy 2017; Granek et al. 2017; Robertson 2008). Older people in hospice and palliative care exhibit a high prevalence of depression, which when untreated increases the risk of complicated grief and suicide (Mayahara and Paun 2023).

The primary goal of palliative care is the best possible quality of life for the individual, and such care should be introduced in the early stages of a serious disease process in parallel with disease-specific treatment (Radbruch et al. 2020). Those receiving palliative care suffer from incurable diseases in which pain and anxiety can occur, leading to the risk of suicide. In addition to known risk factors such as mental illness or a history of suicide attempts, there are more important clinical factors to consider when identifying warning signs. These may include the individual describing a lack of reasons to want to live, experiencing a feeling of hopelessness, or exhibiting withdrawal from friends and family (Hultsjö et al. 2019). Individuals who attempt suicide and those who do take their own lives often communicate their suicidal thoughts and feelings to health-care professionals. One of the most challenging care situations is dealing with suicide and suicide attempts (Hagen et al. 2017). Trust is extremely important in the relationship between the patient and health-care professionals. Interpersonal care qualities and professional competence are the most important factors for developing trust

in the relationship (Ozaras and Abaan 2018). Individuals receiving palliative care often want to be involved in decisions about their care that cover a wider spectrum than just medical interventions (Kuosmanen et al. 2021). Psychosocial and therapeutic interventions can relieve individuals' psychological distress, and multidisciplinary palliative care can help prevent suicide attempts (Akechi et al. 2004; Robertson 2008).

It is important to understand the complex factors that influence how individuals make decisions about their health. It is also important to identify ways to encourage conversations with family, friends, and caregivers to clarify the individual's wishes for end-of-life care (Sorrell 2018). Health-care professionals must consider that intercultural differences regarding underlying values and approaches to death can vary within and between different individuals (Six et al. 2020). Within palliative care, nurses and other health-care professionals have a special role in terms of closeness to the individual and continuity of care (Huisman et al. 2020) and need to be aware of psychological distress of individuals who are in the terminal stage (Akechi et al. 2004). Social workers within palliative care have described that although it is common to meet patients who show warning signs of suicide, they request more knowledge and the ability to care for these patients (Washington et al. 2016). To the best of our knowledge, no previous studies have focused on nurses' experiences. Palliative care integrates the expertise of a team of care providers from different disciplines, and nurses' experiences can therefore contribute additional perspectives on the care of suicidal individuals.

Objectives

The aim of the study was to describe nurses' experiences of caring for individuals who have made suicide attempts within specialized palliative care and to describe if the care of these individuals changed after the suicide attempt.

Methods

Design

A descriptive qualitative method was chosen because it gives participants the opportunity to share their descriptions based on their experiences in their own words (Polit and Beck 2021).

Participants and setting

In order to create variety and not risk capturing a certain culture, an information letter including the aim of the study and a question asking whether the study could be carried out within the specific palliative care clinic was sent to the managers of 5 hospital departments. After the managers had given their approval to conduct the study, information letters were forwarded to nurses including an invitation to participate in the study. Two participants were recruited using this procedure. Broader inclusion via social media was thus applied, and 7 nurses were recruited through a Facebook group for professional nurses. Regardless of the method of recruitment, all participants received written and oral information about the study and its voluntary nature. All informants gave their written informed consent.

A purposive sample was used to ensure that the participants had experience of, and could provide, informative descriptions (Polit and Beck 2021). Inclusion criteria for participation in the study were nurses who currently work or have worked within

specialized palliative care, where euthanasia is not permitted according to Swedish legislation. Experience of caring for individuals who have attempted suicide during ongoing care was required.

Data collection

A semi-structured, inductive interview guide was developed through collaboration within the research team. The guide consisted of open-ended questions, such as "How were you affected when you cared for a palliative individual and he/she attempted suicide?," "Can you describe how conversations take place about death with individuals who have attempted suicide?," and "How did the care change after the suicide attempt?" Follow-up questions were asked to encourage the participants to deepen or develop their previous answers (Patton 2015). Participants were encouraged to talk freely about the topic and describe their experiences in their own words (Polit and Beck 2021). To test the quality of the interview guide, a pilot interview was conducted with an informant who met the inclusion criteria (Polit and Beck 2021). As no changes were made to the interview guide, the interview was included in the analysis. The interviews were conducted digitally as the informants were located across a large geographical area, and the current Covid-19 pandemic was thereby also taken into consideration. The interviews were conducted by xx and xx and lasted between 25 and 48 minutes (mean: 37 minutes). Each informant was interviewed individually. The interviews were recorded as digital audio files and coded to maintain the informant's confidentiality. The files were transcribed, taking inspiration from a transcription guide (McLellan et al. 2003).

Analysis

The analysis followed the conventional content analysis (Hsieh and Shannon 2005). The transcripts were first read through repeatedly to delve into the content and get a sense of the whole. The material was processed to discuss thoughts and impressions. Words, sentences, and key thoughts that answered the aim of the study were highlighted. The codes were sorted by similarities and differences and then formed into subcategories. Depending on the relationships between subcategories, these were organized into a smaller number of categories. The analysis was close to the text in order to avoid interpretation and capture the informants' own words and descriptions (Hsieh and Shannon 2005). Three major areas in the results became categories, with 6 subcategories. The analysis process was a dynamic process that moved back and forth between the different parts. As a final step, 2 of the authors trained in qualitative content analysis evaluated the data analysis to confirm its relevance, which enhances the credibility of the study (Patton 2015).

Ethical considerations

The study was approved by the Swedish Ethical Review Authority (Dnr: 2016/343-31) and was conducted in accordance with the Declaration of Helsinki (World Medical Association 2013).

Results

Nine nurses who had worked in specialized palliative care settings in Sweden for more than 5 years participated. Of these, 7 were

Table 1. Categories and subcategories based on nurses’ experiences of caring for individuals who have attempted suicide in palliative health care

Category	Subcategory
A suicide attempt evokes strong emotions	• Strengthened relationship and compassion with the individual
	• Manipulated and a feeling of frustration
Health-care efforts changed after the suicide attempt	• The team was strengthened with increased efforts
	• The nature of the conversations changed
Experiences for the rest of one’s professional life	• Daring to ask about suicidal thoughts
	• Risks of a superficial relationship

women and 2 were men. The average age was 50 years (range 35–55 years).

The results consist of 3 categories, with 2 subcategories under each category (Table 1).

A suicide attempt provokes strong emotions

In connection with the suicide attempts, the nurses experienced mixed emotions about being manipulated and frustrated. On the other hand, the situation also strengthened the relationship and compassion with the individual. The reason for the strong emotions was that the nurses did not expect a suicidal act in specialized palliative care.

Strengthened relationship and compassion with the individual

Some nurses experienced a strengthened relationship with the individual after the suicide attempt as the individuals opened up about life and formed a relationship in a different way in their conversations. They became vulnerable, which meant that they could communicate more transparently.

I experienced that I came closer to the individual after the suicide attempt and I received a good response from the woman who expressed gratitude for our conversations.

Several nurses expressed that they had compassion for the individuals right from the start due to their disease. Some of the nurses expressed an even stronger compassion for the individual after the suicide attempt, as this was an expression of the individual’s powerlessness in the disease process. One nurse expressed that “the heart bleeds” when something like this happens.

I was very close to the individual and it sounds very strange, but the fact that he attempted suicide shook me and allowed for conversations about death, symptom relief, and a dignified end.

Manipulated and a sense of frustration

Another feeling described was frustration at how the individual was able to attempt suicide when the nurses felt that they had performed good, multi-professional care. The nurses experienced feelings of betrayal and manipulation. The feeling of manipulation arose when nurses said that the individuals hide their suicidal thoughts and plans, instead acting as if everything was fine, and they were satisfied with the care.

We had no feeling he was suicidal at all, quite the opposite. Everything was great. So, we were really duped.

At one point, a close relative of the individual participated in the suicide attempt, which created a great feeling of frustration for the nurse. She had been asked by relatives and the individual about the dosage of pain relief in a way she was not used to. The nurse had also been asked who was responsible for whether something would happen to the dosage. She experienced that they had planned the suicide attempt and went behind her back.

Some nurses examined themselves in the context of the suicide attempts and asked themselves whether they had really done everything they could or if they could have acted in another way to expose the suicidal thoughts and plans.

I myself felt taken advantage of and some became very irritated and angry. I feel that there are still some of those feelings when he is mentioned.

Health-care efforts changed after the suicide attempt

The suicide attempts generated changes in the care of the individual, including increased efforts from the team to allow for better control of the individual’s mental health. The increased efforts also aimed to anticipate that no further suicidal acts would take place through deeper conversations about life and death.

The team was strengthened with increased efforts

After the suicide attempt, the care team’s efforts increased in connection with the individual. Within the team, they gave each other more regular feedback about the individual’s mental health and looked out for signs to ensure that the individual would not begin a suicidal process again.

We had more meetings about the individual and the frequency of visits increased.

Psychiatric specialists, doctors, and a counselor from the palliative care unit were consulted after the suicide attempts. Psychiatric care was consulted in one case to take a view on the compulsory psychiatric care assessment. The nurses were reassured when they received support and advice from psychiatric specialists, as suicide attempts were not common in their work. The nurses and doctors had more ongoing dialogue about the individual’s state of health. In most cases, the counselor was involved to have individual conversations with the individual.

This led to change of course.... The team had much more contact with the individual and each other after the suicide attempt, and psychiatric care was consulted.

The nature of the conversations changed

In several cases, the suicide attempts led to conversations about death, suicidal thoughts, and the reason for the suicide attempt. Several nurses said that the conversations changed in nature after the suicide attempts and became deeper. The nurse and the individual could talk more openly about death and wanting to die. In these conversations, the nurse and the individual discussed how it is not strange to long for death when you have a painful and incurable disease. They could also talk about what prompted the suicide attempt and their feelings surrounding the incident. There was the opportunity for conversations about which aspects of their care could be changed so that the individual would feel better, such as alternative symptom relief or increased conversational contact.

What happened with the conversations was that they changed subject. We talked more openly and deeply about things, and I asked more concrete questions about her mental health.

Experiences for the rest of one's professional life

With increased experience of suicide attempts in palliative care, the importance of daring to ask about suicidal thoughts emerges. A good caring relationship is required in order to ask questions and get honest answers, which was sometimes described as a challenge in palliative care.

Daring to ask about suicidal thoughts

Nurses had a feeling that a suicide attempt could be imminent and therefore did not feel that they could have done anything different in the care process. Some nurses regretted that they had not been more vigilant to the individual's signals and feelings, in order to have possibly been able to prevent the suicide attempt. Several nurses described difficulties in daring to ask questions about suicidal thoughts when they experienced that it was an uncomfortable topic to talk about. It was not taken for granted that the individual would be asked whether they had suicidal thoughts in a palliative care process, where the focus is on relieving suffering and increasing quality of life. However, something that most nurses took with them after the suicide attempt was an awareness that suicidal thoughts and suicide attempts can occur in palliative care and that it is necessary to ask questions about suicidality. None of the nurses used any assessment instrument to assess suicide risk or assessed whether there were any feelings of hopelessness.

After this suicide attempt, I became much more alert when I received unusual signals. That's a warning sign for me. I take that with me, that it is important to dare to ask further when things do not feel like they usually do.

Risks of a superficial relationship

Some nurses experienced that they did not get close to the individual, which was often caused by the individual having a strong character or great suffering. The caring relationship then instead became superficial, which the nurses subsequently perceived was a risk factor for the individual to carry out a suicidal act. A superficial relationship was experienced when the individual was dismissive and not particularly communicative and declined proposed initiatives that often involved supportive conversations. This also led to conversations about symptom relief often not taking place, as the individual was highly introverted. The nurses described the importance of having a good relationship with the individual in order to expose suicidal thoughts and that a good relationship meant a feeling of shared trust, openness, and honest communication.

There was no one among the staff who felt that they had good contact with him, and there perhaps you should have thought that it was a risk factor.

Discussion

The main results show that a suicide attempt arouses strong emotions. Feelings of manipulation and frustration were explained in relation to all interventions and resources offered. Furthermore, the nurses described that palliative care offers opportunities to talk about these difficult questions, about life and death. It appears that the health-care efforts changed after the suicide attempt, becoming even more extensive. The nurses described how the knowledge they acquired became experiences for the rest of their professional lives.

The results reveal feelings of being manipulated and a sense of frustration, which is also found in previous research (Scott et al. 2009). Although a feeling of being manipulated may arise among health-care professionals, this is probably not the patient's intention. However, our results also show that there is compassion for the individuals. Nurses who experience an individual's suicide attempt describe feelings of worry and stress and that they will be blamed for the event (Türkçeş et al. 2018). The main responsibility for offering good palliative care lies with health-care staff and those who provide palliative care (Kuusmanen et al. 2021). When an individual in palliative care attempts suicide, it is therefore understandable that the nurse will feel frustrated about the situation and may wonder if it was a failure on their part.

The results show that nurses caring for individuals who attempt suicide express detailed and deep memories of the event, even if it occurred several years earlier. Nurses who have experienced an individual's suicide attempt describe a quest for reparation and a feeling of sadness (Amit Aharon et al. 2021; Caputo 2021) and need support afterwards (Amit Aharon et al. 2021). This support can include managing emotional experiences and self-reflection to develop coping strategies. Furthermore, knowledge about suicide and support to face negative events can be helpful (Shao et al. 2021).

The results also show that suicidal thoughts and suicide attempts occur in palliative care. Previous research shows that individuals in palliative care have an increased risk of suicide attempts (Granek et al. 2017). This may be because they lose control of their own life and future death, and the suicide attempt is thus interpreted as a last use of their autonomy. Severe physical illness can also pose a risk of suicide (Conwell et al. 2010). Nurses therefore need to have strategies for identifying risk factors for suicide. Thus, knowledge about an increased risk of suicide in certain patient groups – including those affected by cancer – is important. The increased suicide risk is associated with symptoms of being a burden to others, a lack of social support, low physical functioning, and depression (Sullivan et al. 2018).

Most nurses describe changes in the care of the individual, including in the way of communicating after the suicide attempt. Nurses can develop the ability to communicate on a deeper level during difficult, unpredictable events. A highly effective way to prevent further suicide attempts is to communicate with the individual and their family (Katsivarda et al. 2021). Thus, it is important for nurses to dare to ask questions about suicidal thoughts. Research has shown that short educational interventions in a primary care context help nurses to feel secure when asking about suicidal thoughts and plans (Solin et al. 2021). Hospice and palliative social workers suggest that more education on suicide prevention would be valuable in their work (Washington et al. 2016). There is therefore reason to believe that this type of intervention would also be effective for nurses working in palliative care. Previous research describes the importance of using advanced communication skills with an individual who attempts suicide. This can involve talking about the meaning of life, facing reality, and practicing acceptance (Chi et al. 2014).

Nurses described how efforts around the individual increased after the suicide attempt. Michaud et al. (2021) illustrate how individuals who have attempted suicide appreciate the nurse's professional involvement in their aftercare, and they also appreciate more meetings and more follow-up calls. Younes et al. (2020) mention how GPs become more involved in the individual's care after a suicide attempt. Individuals who attempt suicide place value on staff who are committed, both humanly and professionally

(Michaud et al. 2021). It may seem that these extra measures should have been in place before the suicide attempt. Nurses in palliative care should be given the opportunity to identify those individuals who have an increased risk of suicide attempts. Involving close relatives with knowledge about the individual's thoughts and feelings can be valuable (Seipp et al. 2021).

Further, an ethical dilemma arises for many nurses, as palliative care advocates a good quality of life and a comfortable end to life, whereas the individuals who received palliative care instead try to take their own lives. The experience was an exceptional event for the nurses, and guidelines for this situation were missing in several of the care units. The phenomenon being studied raises several ethical questions. Caring for an individual with a terminal illness is complex. It can be difficult to assess whether a wish to end one's life in a palliative stage can be considered rational (Mayland and Mason 2004). According to Gramaglia et al. (2019), conclusions about the rationality of patients' decisions about ending their life should be avoided, even though the possibility of rational suicide cannot be ruled out.

A superficial relationship with the individual is considered a risk factor for suicide attempts in palliative care. It appears that most nurses find it difficult to talk about suicidal thoughts. Individuals who attempt to take their own lives often communicate their suicidal thoughts to staff (Rytterstr m et al. 2020), which does not appear in our results. This may be because it is difficult and possibly shameful for the individuals to express their suicidal thoughts within palliative care. The social condemnation of suicidal thoughts is a stress factor among individuals who experience or have experienced these, and stigma is considered a barrier to seeking help (Oxle et al. 2020).

Some nurses find it difficult to talk about imminent death and that not all patients in palliative care want to talk about death (Verschuur et al. 2014). Some nurses mention that they did not discuss or assess feelings of hopelessness in the individuals, which could be a possible explanation for not getting close enough. Discussing and assessing hopelessness can help health-care professionals minimize suicide attempts (Clua-Garc a et al. 2021; Efsth iou et al. 2018). Hope can be instilled by helping the individual to achieve smaller goals and thereby gain a sense of hopefulness. The ideal conditions for creating a good relationship of trust arise when the nurses meet the individual in an early stage of palliative care (Verschuur et al. 2014).

The results indicate that some nurses find it difficult to reach individuals who are perceived as introverted, which may be why the caring relationship is perceived as superficial. In these cases, it is considered easier if nurses have access to an accepted assessment instrument, such as the Hospital Anxiety and Depression Scale or the Edinburgh Depression Scale (Lloyd-Williams et al. 2003), to succeed in capturing the dark thoughts that may exist. At the same time, research has shown that accepted instruments for assessing suicidal risk have low validity (Runesson et al. 2017). Therefore, the personal relationship between the nurse and the individual is of crucial importance.

Methodological considerations

Due to the difficulties in recruiting informants within county council-affiliated specialized palliative care in a Swedish region, it was decided to search for additional informants through a Facebook group for nurses. In this way, 7 informants were found. This made it possible to reach a larger geographical area and thus avoid the risk of capturing a local care culture (Patton 2015).

A sense of anonymity that can arise during digital interviews can contribute to the informant being more sincere and open. When studying a sensitive area, such as suicide, there is a risk of social desirability, which means a tendency for people to present themselves in a generally favorable fashion (Holden and Passey 2009). In this study, we experienced honest, genuine answers and that the informants shared how challenging the work was with suicidal patients in palliative care. The study includes 9 informants. Additional informants would have been desirable, as 9 participants can be considered to be too few. However, it was considered sufficient to achieve good validity based on the purpose of the study. After completing the series of interviews, data saturation was experienced (Polit and Beck 2021).

Quotations from the interview material were used to increase the credibility of the results (Hsieh and Shannon 2005). The transferability of a study depends on the similarities between the context in which the study was conducted and the context in which the results will be used (Patton 2015). This study was conducted in Sweden, and the reader must therefore understand that it was performed in a context of specialized palliative care according to Swedish guidelines.

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