

**ATTENUATING ANXIETIES - MENTAL HEALTH NURSES' RESPONSES TO SUICIDAL
BEHAVIOUR: A GROUNDED THEORY STUDY**

**A thesis presented to the University of Dublin, Trinity College for the Degree of
Doctor in Philosophy**

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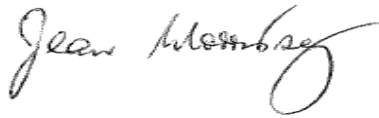
October 2014

Declaration

This thesis has not been submitted for an assessment at this or any other university and the work herein represents the sole work of the author.

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Signed:

A handwritten signature in cursive script, appearing to read "Jean Morrissey".

Jean Morrissey

Summary

Title: Attenuating Anxieties: Mental Health Nurses' Responses to Suicidal Behaviour: A Grounded Theory study

Background: Both nationally and internationally, suicide and suicidal behaviour are major public health issues and concern. Suicide risk is also a problem for people with mental health problems who form a considerable number of the overall presentations to both hospital and community mental health facilities in Ireland. Mental health nurses are at the frontline of service provision to this client group and have an important role to play in suicide prevention. However, there is limited research available that explores this complex area of mental health nursing practice.

Aim: The aim of this study was to develop a grounded theory that explained how mental health nurses within a mental health service in the Republic of Ireland, respond to clients who present with suicidal behaviour.

Methodology: This study was informed by a constructivist epistemology and the principles of Grounded Theory as described by Glaser. Data was gathered in one mental health service in an urban area in the Republic of Ireland. Participants comprised thirty-three nurses who were working in a variety of in-patient and community-based clinical areas. Data was collected through interviews and analysed using the concurrent processes of constant comparative analysis, theoretical sampling, theoretical sensitivity and memo writing.

Findings: The participants' main concern about caring for suicidal clients was related to their feelings of professional and personal vulnerability and the need to protect both clients and themselves. Being cognisant of the enormity of their responsibility and the uncertainty of being able to ensure clients' safety, they resolved their main concern by attenuating their anxieties throughout the different stages of caring for the suicidal client. The participants dealt with these concerns through a process conceptualized as '*Attenuating Anxieties*', which had five subcategories, most of which contain a number of related subcategories and properties.

The first phase of this theory '*Learning the discourse of anxiety*' forms the bedrock of the theory wherein the participants' learnt to be anxious about caring for a client at risk of suicide. After this phase, the participants moved to clinical practice wherein they '*cultivate anxieties*' around caring for a client at risk of suicide and developed a repertoire of strategies for protecting the client and '*managing their anxieties*',

Some participants recognised the need for further education and skills and went on to undertake further education and attend clinical supervision. For this group, pursuing further education was a significant critical juncture (Glaser 1978, p.100) and resulted in them developing strategies to '*contain anxieties*'. While this group also safeguarded against anxieties in the event of a client suicide, in contrast to their colleagues they have a place to process their feelings and anxieties, and learn from their experience and consequently are able to return to '*containing anxieties*' as opposed to engage in '*managing anxieties*' strategies. While the theory is presented in a linear format for presentation purposes in reality practices were much more iterative and interrelated.

Conclusion: This substantive theory adds to the body of knowledge by identifying how the participants in both in-patient and community mental health services dealt with their need to protect clients and themselves along with the various strategies they used to allay their anxieties when working with the suicidal person. Participants worked hard to fulfil their primary task and allay their anxieties by utilising historically known strategies to care for the suicidal person. Such practices were not only restrictive in terms of the client's freedom but also promoted a practice that did not value the importance of therapeutic engagement and emotionality beyond the rhetoric. Clients who engaged in self-harm continued to experience the negative effect of being cared for by practitioners who knew little about or demonstrated an interest in discovering the meaning and function of self-harm, beyond that of the client's behaviour. In parallel to this, practitioners also experienced a professional discourse wherein the impact of client suicide beyond that of anxiety continues to remain secretive and unspoken. Nonetheless, the acquisition of further psychotherapeutic training, clinical supervision as well as increased reflexivity and belief in self and clinical work protected some participants, and enabled them to feel more informed and thereby more contained to work creatively and collaboratively while supporting and facilitating therapeutic risk taking. This study raised several

implications in terms of how nurses at undergraduate and post graduate level are prepared to work with and respond to clients with suicidal behaviour in a competent, compassionate manner. At the same time, the study highlights the need for protected time wherein nurses will have a safe supportive thinking space to reflect on their anxieties and learn from their clinical work while taking therapeutic risk when working with suicidal clients.

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Chapter One: An Overview of the Thesis

Introduction

The extent of suicide and self-injurious behaviours has become a major public health issue and a major cause for concern worldwide (Fleischmann & Shekhar 2013). Globally, suicide is among the ten leading causes of death accounting for approximately 1 million people dying by suicide each year and a projected increase to 1.5 million deaths annually by the year 2020 (Bertolote & Fleischmann 2002, Cole-King *et al* 2013). In the European Union (EU), suicide is a major cause of death with about 58,000 suicides per year, of which 75% are by men (Hegerl & Wittenburg 2009). Suicide is one of five key priorities in the European pact for Mental Health and Well-Being (European Pact for Mental Health and Well-Being 2011). In Ireland, suicide and suicidal behaviour has become an increasingly serious public health issue and concern. Ireland has the sixth lowest rate of suicide in Europe, with a reported rate of 10.3 per 100,000 population (NOSP 2012), however, it ranks fourth highest in the EU for deaths by suicide for 5-24 year olds - 13.9 per 100,000 population. The highest rate is among young 20-24 year old males at 31.9 per 100,000 population. Over the last decade, this gender differentiation is a constant feature of the deaths by suicide. The high rates of suicide and in particular among young males has propelled suicide and its reduction to the fore front of health policy and research both nationally and internationally.

Non-fatal suicidal acts and other self-harm behaviours occur much more frequently than completed suicide with most acts of self-harm hidden; consequently they never come to the attention of mental health professionals. In 2011, there were 12,216 recorded presentations to hospital due to deliberate self-harm (DSH), with drug overdose being the commonest method of self-harm involving over two-thirds (9,834) of individuals (National Suicide Research Foundation (NSRF) 2012). Cutting was the other common method of self-harm involved in all episodes. Although the female rate of DSH is higher than the male rate, differences between male and female rates have been narrowing from 37% in 2004-2005 to 13% in 2009-2010 (NOSP 2006, 2010, 2011, 2012). Nonetheless, as stated earlier given the secretive nature of self-harm, many incidents are never reported and as such go unregistered.

Suicide and self-harm affects many people directly both in a personal and/or professional capacity and indirectly. Death by suicide has a devastating and long-lasting effect for families, friends and mental health professionals including mental health nurses, as they try to come to terms with sudden death and in many situations the significant loss of a family member and/or loved one. Similarly, self-harm can impact immensely on families, friends and mental health nurses, who all struggle to understand the meaning and function of self-harm together with the fear of the behaviour escalating to a suicidal act. Suicide risk and self-harm is also a problem for people with mental health problems who form a considerable number of the overall presentations to both hospital and community mental health facilities in Ireland. For those working with clients¹ who are suicidal and who engage in self-harm, such as mental health nurses, suicide and self-harm prevention and harm-minimisation is obviously a priority.

Over the years, societal beliefs and attitudes about suicide have varied considerably in many countries including Ireland. In general, legislation in different countries has been influenced by different cultures' view of suicide, and in particular various religious communities. Consequently, suicide is no longer considered a crime or sin in many countries (O'Connor *et al* 2011), including Ireland having been decriminalised in 1993, albeit Ireland was the last country in Europe to abolish the punishment for suicide attempts. Notwithstanding such significant societal and legal changes, suicide and in particular self-harm, still evoke a wide range of attitudes and responses, some of which are value-laden and pejorative. In addition, the stigma associated with suicide can influence peoples' beliefs and opinions about suicide, which can differ between and within different helping professionals, institutions, societies and persons at risk of suicide. Such diverse views may influence not only how people including health professionals respond to the suicidal person but also whether people at risk of suicide ask for help or tell people about how they are feeling. A positive and open attitude towards those who engage in self-harm and suicidal behaviour and their families is critical to engage with the person and to support and promote the person's safety and well-being.

¹ Although I am aware of the ongoing debate around the suitability of using terms such as patient, client, consumer and service user; for consistency, I have chosen to use the term client given that it was the term most frequently used by the participants in the study.

Unfortunately, considerable evidence suggests that people who have experienced self-harm often feel they get a mixed response from service providers with whom they come in contact with (Pembroke 1996). Negative stereotyped attitudes about people who experience self-harm, results in men and women often feeling criticised, blamed, rejected or having their self-harm (distress) minimised by the use of pejorative terms such as, ‘cutters’, ‘attention-seeking’, ‘manipulative’ and/or being labelled ‘PDs’ (Personality Disorder) (Babiker & Arnold 1997, Inkle 2010a). In the UK, The National Institute Health and Clinical Effectiveness (NICE) (2004, p.7) acknowledged that the level of care provided in emergency services following an episode of self-harm was “often unacceptable”. In addition, concern has also been raised not only about poor standards of care and management but also about the negative attitudes and feelings of irritation and anger received from frontline staff directly involved in the care of people who self-harm (NICE 2004).

Mental health nurses are at the frontline of service provision and are likely to encounter in almost every practice setting people who experience thoughts of suicide or they may work with people who have attempted suicide. They are therefore in a pivotal position to utilise their knowledge and skills to assist people who present with self-harm and suicidal behaviour and as such, have an important role to play in suicide and self-harm prevention and reduction. However, despite the potential to offer therapeutic interventions to those at risk of suicide and self-harm, how mental health nurses should go about this is not explicitly understood (Cutcliffe & Barker 2002). In addition, little is known about whether mental health nurses are adequately equipped with the skills and interventions designed to work with the specific needs of people at risk of suicide or self-harm using the services. This is in line with discourse, which insists that intervention decisions and clinical practice are benchmarked in line with the key priorities of Reach Out, the National Strategy for Action on Suicide Prevention (2005-2014), (NOSP 2005) and good evidence-based parameters.

Although the phenomenon of suicide and self-harm is well documented in the nursing literature, there is limited empirical data, which informs mental health nurses how to care for this client group and even less empirical evidence to support specific interventions (Cutcliffe *et al* 2006, Cutcliffe & Stevenson 2007). To date much of the nursing literature on suicide and self-harm is primarily guided by a traditional

biomedical knowledge of suicide and self-harm. In addition, most of the published nursing research has focussed on attitudes and issues relating to practices of care primarily within in-patient settings, the majority of which have been undertaken outside the Irish context.

Generating the idea

Identifying how or when the idea for this research project emerged is not an easy or straight forward task. Although the idea began formally when I wrote the application proposal for admission to the PhD programme; its origins started many years earlier when I was working as a mental health nurse. During that time, I was confronted with challenging situations related to the care of the suicidal person and the person who engaged in self-harm, wherein I struggled with not knowing what to say to the distressed person with suicidal ideation or who engaged in self-harm due to my lack of confidence, skills and understanding at the time. Mental health nurses have been involved in the care of the suicidal person since the inception of formal mental health services. In recent years, there is increasing interest in providing training to help mental health nurses work more effectively in different health settings with clients who experience suicidal thoughts and engage in suicidal behaviour and self-harm across the lifespan. Notwithstanding this, being convinced that suicide and self-harm rarely leaves mental health nurses in a neutral position, I wondered how nurses' beliefs and feelings might influence how they connect, engage and communicate with the person who is expressing suicidal thoughts or behaviours. A review of the literature in mental health nursing suggested that no theoretically robust or empirically induced information existed on how such care can and should be carried out. Therefore, I set out to explore how mental health nurses responded to clients who present with suicidal behaviour.

Aim of the research

The overall aim of this study was to examine how mental health nurses respond to clients who present with suicidal behaviour.

Research question

Identifying an exact and accurate research question in a grounded theory study is not possible (Hutchinson 2001) as the focus of the research problem should emerge from

the data (Glaser 1992). Essentially, the grounded theory researcher enters into an area of interest with no problem, but instead with a topic area to examine. However, given the broad subject area for this study I believed it was important to have one overall aim, which would help to focus the research at the early stage of the study. The following were the tentative aims:

- to explore how mental health nurses conceptualise suicidal behaviour in the context of mental health nursing practice
- to elicit how mental health nurses respond to clients who present with suicidal behaviour
- to identify the factors that influence the way mental health nurses respond to clients who present with suicidal behaviour

Selecting grounded theory as a research methodology

This study employed Glaser's approach to Grounded Theory (Glaser 1978, 1998, 2001, 2003 2005). Grounded theory was chosen because I wanted to produce an outcome of a model or theory that might impact on clinical practice. After studying the various approaches to conducting a grounded theory study and attending workshops facilitated by Dr. B. Glaser on the respective method, I decided to adopt Glaser's approach to the study. Glaser's style of grounded theory was considered the best suited approach for this study and for the following reasons. It allows the development of knowledge in a complex area of health care and an area where little is known; it lets the problem emerge from the participants' perspective and finally it seemed flexible enough yet rigorous, to allow me the freedom to follow leads and use a variety of data collection methods or ideas.

A personal statement

The following personal statement is intended to help the reader judge to what extent this thesis is influenced by my personal prejudices. At the outset, I do not believe that the 'personal me' can be separated from the 'professional me', whether in my role as researcher, teacher, mental health nurse or clinical supervisor. However, I am mindful that what I disclose about myself should be context specific and at the same time I recognise that all my thinking and learning about suicide leave imprints albeit subtle, which may be revealing. As a nurse with over twenty five years in mental

health and general nursing, I have been touched by client suicide as a person and professional.

My earliest awareness of suicide was through the hushed and secretive conversations that I overheard in my family about a neighbour who died suddenly because “*she walked into the sea*”. As a child, details of the woman’s death were not for my ears and I was discouraged from asking any questions. As a result, suicide was a mysterious and secretive event. My first real experience of suicidal behaviour was through my early employment as a general nurse. This was the first time I had come into personal contact with the process of living and dying. Working on a medical ward with people following attempted suicide illustrated the psychological pain and existential crises that contribute to an individual considering ending their life. As a general nurse, I became familiar with the process of dying and cared for many dying people. However, death for the most part was a consequence of age or disease and as such it could be explained as part of the natural progression of life. It was not until my early mental health nursing career that client suicide began to impinge on me more closely and resulted in having to attend a coroner’s court. After being exposed to the death of a client through suicide, I felt frightened and professionally vulnerable. Privately and with the support of a few trusted colleagues, I reflected on and discussed what I did to help this client and questioned whether I could have done more to have prevented the person’s suicide. I felt a range of emotions - sad, fear, guilt and anger. Listening to my colleagues’ experiences and responses gave me some comfort and helped to allay my sense of isolation and burden. While working and caring for people who were considered to be a potential suicide risk, I became increasingly aware of my need to protect myself from the possibility of future client suicide and the fear of being blamed by relatives and the organisation. Such fears took the form of engaging in ritualistic practices such as completing checklists coupled with not trusting clients to take positive risks. Although unaware of it, over time I began to reflect on how I might engage and work with suicidal clients in a more compassionate and person-centred way, which motivated me to discover and learn more about less-defensive approaches to caring for the suicidal person.

As the author of this thesis, it is evident that I consider effective communication essential when engaging with people who are suicidal or engage in self-harm in order to support the person to prevent the immediate risk of suicidal behaviour, while at the

same time facilitate the development of a positive helping relationship. Over the years this has led to my increased reading about suicidality, on-going development of therapeutic skills and reflexivity, so that I can apply the theory and skills of working with the suicidal person within nursing curricula and courses that I involved in teaching.

Format of the thesis

The thesis is presented in three sections. Section One focuses on the literature in the substantive areas (chapters two and three). Although a preliminary literature review was conducted prior to the inquiry, this was not used as a theoretical framework for the study. To contextualise the topic of suicidology within the wider discourses in the field, the first chapter of the literature review (chapter two) examines various discourses that have shaped our understanding of suicidology. In chapter three, I draw on a range of empirical research to provide the reader with an overview of the current state of knowledge in the area of suicidology and mental health nursing.

Section Two describes the epistemological, ontological and methodological propositions that informed the study (chapter four). A discussion on the Glaserian approach to Grounded Theory, with particular reference to how this method differs from other Grounded Theory approaches is included. In this chapter I also address the role of reflexivity and Grounded Theory. Chapter five addresses the practical issues in relation to how the study was operationalised. Issues in relation to access, sampling, data collection, data analysis and ethical issues associated with conducting research on a topic that could be considered sensitive are discussed. In this chapter, I also endeavour to capture the methodological ethical and personal challenges I encountered and some of my own learning and reflections on the process of conducting this research.

Section Three presents and discusses the substantive grounded theory “Attenuating Anxieties”, which represents the findings from the study. The emergent theory is described in chapters six to ten. A discussion of the theory in the context of extant theoretical and philosophical literature is provided in chapter eleven. Chapter eleven, the final chapter, also addresses the limitations and implications of the findings, and includes recommendations for education, clinical practice and research. This is

followed by Glaser's criteria of fit, workability, modifiability and relevance to evaluate the trustworthiness of the emergent theory. The thesis concludes with some reflective thoughts about the process and impact of undertaking this thesis on me as a person, theorist and researcher.

Chapter Two: Discourses on Suicidology

Introduction to the literature review

In order to contextualise the subject of suicide and suicidal behaviour within the wider discourses in the field of suicidology, this chapter examines various discourses that have shaped our understanding of suicidal behaviour. While the history of suicide charts the ongoing development of various discourses and their efforts to define and understand the nature and meaning of suicide; this discussion on suicidology is not intended to be a history of suicidology in a chronological sense. Furthermore, it is not intended to purport that there is a single *truth* of suicide. Instead, the focus of this chapter is to present the various discourses that have shaped and informed our understanding of suicidology. Discourse refers to the way certain ideas and beliefs are put together in this context about suicidology, in order to present an idea in a particular way, at a particular historical period. According to Mills (2003, p.54) a discourse comprises:

“a set of rules and procedures, assigned roles and positions; it regulates behaviours and what can be said and produces hierarchies”.

Historically, a multitude of perspectives and scientific positions have been put forward to explain the aetiology and course of suicidology. These have included bio-medical, psychological, and socio-cultural perspectives. Each discipline develops its own particular discourse, which contributes to the construction of a composite discourse of suicidology. For Foucault, such discourses can be understood as language in action, which provide openings to help us to see and make sense of things (Danaher *et al* 2007). Rejecting the idea of the self-governing object, Foucault believed that these discursive explanations not only shape our understanding of ourselves, but also our capacity to or be driven by instinct. He argued that our thoughts and actions are influenced regulated and to some extent controlled by these different discourses, which according to Danaher *et al* (2007, p.31) “help us to distinguish what is the valuable from the valueless, the true from the false and the right from the wrong”. In other words, discourses affect our views on all things and therefore are impossible to avoid. However, discourse is not only a language that reflects the social order but one that also contributes to its creation. According to Foucault (1977), discourses set up relationships with other discourses; they share a

space and establish contexts, and over time, they may also disappear and be replaced by other statements and subsequently discourses. Notwithstanding this, Foucault (1977) argued that discourse is related to power as it operates by rules of exclusion and should be seen as something that constrains our perceptions. However, unlike Danaher, Foucault would not view discourse as helping us to identify truth from the false, but would see some discourses as holding greater sway and subjugating others.

In the context of mental health, suicidology is believed to result from the interaction of several different discourses that have influenced the study of suicidology and have shaped and reshaped how suicide and suicidal behaviour is understood. Shneidman (1993) asserts that suicidology consists of the study of biopsychosocial, interpersonal, intrapsychic, logical, conscious and unconscious and philosophical factors in the suicidal event. Furthermore, as Leenaars (2004) points out it is a multidisciplinary enterprise, since most suicidologists believe that no single discourse on its own will ever be able to explain sufficiently the phenomena as varied and as complex acts of human self-destruction. While there are inevitably differences in emphasis within and between each discourse, an understanding of each discourse and its influence in the field of suicidology needs to be considered in order to enhance our knowledge and understanding of suicide and suicidal behaviour. Notwithstanding, it is beyond the remit of this chapter to explore every theory or every writer; discourses are therefore limited to the works and writers that are viewed as significant in the respective field.

Role of the literature in a Grounded Theory study

One of the most debated and misunderstood aspects of grounded theory concerns the use of the literature (Walls *et al* 2010, Birks & Mills 2011). In a grounded theory study a literature review in the substantive area is usually contraindicated in the early stages of the study. Originally, Glaser & Strauss (1967) took the position of delaying a formal review of the literature until the data has been analysed. This stance was reiterated by Glaser in subsequent texts (1992; 1998; 2005). For Glaser (1992, p.31), this dictum was “brought about by the concern that literature might contaminate, stifle or otherwise impede the researcher’s efforts to generate categories”. Following this dictum helps the researcher to remain open and as free of influences as possible and thereby reducing the risk of contaminating and constraining the analysis of data

with any extant ideas or knowledge. Glaser (1998, p. 67) argues that undertaking an extensive review of the literature restricts the freedom required for theoretical discovery and may result in the forcing of the data; he concludes that the likely outcome of a pre-research literature review is “inimical to generating grounded theory”. As such, Glaser’s dictum concerning the literature is designed to ensure that the researcher takes an inductive rather than a deductive approach and listens to the data rather than imposing preconceived ideas on data.

Over the years as the methodology evolved, Strauss (1987) and Strauss & Corbin (1990) altered their position and recommended a preliminary review of the literature to assist in the development of theoretical sensitivity and to provide justification for the study (McCann & Clark 2003). As McGhee *et al* (2007) point out, the issue is not whether a literature review should be conducted but instead, when should it be conducted and how extensive should the review be. For the majority of researchers some form of preliminary review of the literature cannot be avoided as a literature review is usually necessary to meet the requirements of local ethics research committees and research funding bodies (Cutcliffe 2005). While Glaser (2001, p.114) acknowledges that researchers often need to undertake a “compromised GT proposal” that is, a proposal written which conforms to meet such requirements and in order to proceed with the study; he stresses the importance of the researcher having an open mind and taking an objective view of the knowledge acquired from the literature. Glaser’s position remains clear, the researcher should not conduct a detailed literature review in the substantive area, not just because the literature is irrelevant but because similar to the discovery of the theory, the literature that is relevant has to be discovered (Glaser 1998). Nevertheless, Glaser (1998) does encourage reading during the research process but in substantive areas, which will not conceptually contaminate the emerging theory and will increase the researcher’s level of theoretical sensitivity.

In the context of this thesis and as part of the requirement for academic registration a preliminary literature review was conducted prior to the study. However, it was not used as a theoretical framework to guide the study but instead to help develop theoretical sensitivity, that is, the ability to sense the subtleties of the data (Glaser 1978). According to Glaser (1998, p.8) conducting the literature search in the substantive area occurs when the grounded theory is nearly completed during the

sorting and writing-up stages of the study and is treated as another source of data – “all is data” to be integrated into the constant comparative analysis. Therefore, “the literature is discovered as the theory is” (Glaser 1998, p.69). A literature search was therefore conducted parallel to the data analysis and during the final stages of theory development and writing up. All literature read at this stage related to the emerging theory. In this chapter, the literature² presented was collected prior to undertaking the study and subsequently refined as the study progressed.

The language of suicidology: Multiple terms, nomenclature and classifications

Before discussing the different discourses on suicidology it is important to consider the language and nomenclature of suicide and suicidal behaviours. Suicide and self-harm are complex behaviours, highly sensitive and the subject of much debate and discussion among clinicians and researchers in the field of suicidology. These issues are further compounded by the fact that the language used to describe suicidality, a term used to describe a broad range of suicidal cognitions and behaviours (Silverman 2006) and self-harm is often used in different contexts as though there was a shared and agreed meaning of the terminology used. Clinicians and researchers have both struggled to reach a consensus about which terms, nomenclature and classifications will provide the most clarity and sensitivity to suicide-related and non-suicide related thoughts and behaviours (Jacobson & Gould 2007). Nonetheless, in the growing scientific and knowledge base literature on suicidology there is an increasing number of different terms, which are often used interchangeably to describe the same behaviour (Fairbairn 1995, Hawton & van Heeringen 2000, O’Connor *et al* 2011). Terms commonly used throughout the international literature include: self-harm, deliberate self-harm (DSH), parasuicide, attempted suicide, suicidal behaviour, non-suicidal self-injury self-injurious behaviour and self-mutilation. In Ireland, the National Strategy for Action on Suicide Prevention (NOSP 2005) uses the term suicidal behaviour as an umbrella term, which encompasses the spectrum of

² Literature both national and international from a multiplicity of disciplines was identified through a number of methods. Searches of electronic databases such as PubMed, PsychoINFO, Google Scholar, CINAHL, Psychlit, were carried out using key words: suicide, self-harm, deliberate self-harm, suicidal behaviour, mental health, mental illness, psychiatric nursing, attitudes and suicide, attitudes and self-harm. Key websites in the area of mental health and suicidology were also searched and some unpublished thesis was accessed through inter-library loan. Further information was accessed through books held in University of Dublin, Trinity College library and other libraries. In addition, I attended workshops and seminars with some key writers in the area suicide and self-harm from the UK, which also highlighted some relevant sources.

activities related to suicide, including suicidal thinking, self-harming behaviours not aimed at causing death and suicide attempts (Commonwealth Department of Health and Aged Care [Australia] 1999). The distinctions between these terms are beset by inconsistent and blurred terminology (Jacobson & Gould 2007). The following examines how the nomenclature and language of suicide, suicidal behaviour and self-harm is defined and more importantly is understood in the literature and clinical practice.

Defining suicide

Suicide is universally understood as an intentional or deliberate self-inflicted act, which results in death (Shneidman 1985, Maris 2002). Suicide therefore occurs when a person dies by his/her own hand; it is a death by oneself. However, Pritchard (1995) points out that the definition of suicide is initially deceptively simple. While all suicides are individual acts, they may reflect degrees of societal, social, group or cultural pressure (Shneidman 1993). Throughout the expansive literature there is a general consensus about the broad concept of suicide, yet nearly thirty years after Shneidman's (1985) comprehensive text, which focussed on definition and was aptly called "Definition of Suicide", there is still no universally accepted definition. Consequently, numerous different definitions of suicide exist throughout the scientific literature (Silverman 2006). For most countries reporting to the World Health Organisation (WHO) (1992) cause of death is classified according to the WHO's International Classification of Diseases, Injuries and Causes of Death (ICD 10). Deaths by suicide fall within the category of deaths by external causes, along with deaths under one of the four possible modes of death - Natural, Accidental, Suicidal and Homicidal (NASH) (Leenaars 2004). Ireland, as in the UK and Australia operates a coronial system whereby a verdict of suicide is determined by a coroner. However, in Ireland a police opinion concerning the nature of the death is sought (Corcoran & Arensman 2010a) before the coroner will make a decision based on the 'beyond reasonable doubt' legal approach. In other countries for example Finland, possible suicides are investigated by the police whereas in China, physicians are involved, who may take a 'balance of probabilities' approach (Hawton & van Heeringen 2009). A verdict of suicide may therefore be defined differently depending on the purpose of the definition for example, medical, legal or public health. As a result, different professional groups for example researchers, clinicians, epidemiologists require different standards of evidence and levels of certainty for

such evidence as well as place different emphases on different aspects of evidence and different measures to record their findings (Silverman 2011). Determining death by suicide is further compounded by the fact that the criteria used also varies between and within countries, along with the standard of proof required before a suicide verdict can be recorded, for example, the presence of a suicide note or intent of self-inflicted injury (Hawton & van Heeringen 2009). When determining the cause of death, the key question for the medical examiner or coroner involves not only deciding whether the person killed him/herself but also whether he/she intended to die. As such, a verdict of suicide is decided on evidence that focuses on the issue of intent.

Establishing the evidence of intent to die is an important factor in a suicide verdict, however, it is often difficult to determine intent in certain situations for example, very often what the person intended is unknown or that he/she knew that a specific act would probably result in death, such as swallowing a fatal number of tablets (Rosenberg *et al* 1988, Pritchard 1995). Finally, it is important to note that since suicide is no longer a crime in many countries including Ireland, having been decriminalised in 1993 (Corcoran *et al* 2006); it is considered inappropriate and indeed unhelpful when describing death by suicide to use value-laden terms historically referred to as '*committed suicide*'. The preferred term is '*died by suicide*' as recommended by The Irish Association of Suicidology and the Samaritans, in their Media Guidelines for the portrayal of Suicide (2010).

Defining self-harm

Similar to suicide, defining self-harm is not an easy task. Self-harm is a complex and multidimensional issue (Turp 1999a, 1999b). There is general consensus within the literature that conceptually self-harm and suicide are different, and that there are significant differences between act(s) of self-harm and behaviour(s) that are suicidal in nature, and not only differences in the outcome (Turp 2003, Muehlenkamp 2005, Cutcliffe & Stevenson 2007). Notwithstanding this, the use of different terms pertaining to self-harm such as, deliberate self-harm (DSH), self-injury, non-suicidal self-injury (NSSI), suicide attempt still persist both in clinical practice and throughout the literature. For many authorities and researchers in this substantive area, self-harm includes both intentional self-injury and intentional self-poisoning irrespective of whether or not suicidal intent is present. Proponents of this broad

definition include both self-injury and self poisoning into self-harm research (Oughrin 2012). In contrast, others researchers for example, Babiker & Arnold (1997) and Inkle (2010a) differentiate between suicide attempts and non-suicidal self-injury, and view self-injury as a specific condition that is most commonly used as a strategy to regulate mood. Both perspectives will be briefly described below.

The act of self-harming may present in various ways ranging from the highly dramatic and visible to the virtually innocuous and invisible, as well as holding multiple meanings for each individual who enacts the behaviour (Turp 2003, Inkle 2010a, 2010b). Taking a very broad definition, self-harm can be used to include a wide variety of self-injurious or health-impairing behaviours that may be incorporated into the lifestyle of many people for example smoking, binge drinking, or alternatively self-harm by omission for example not wearing a seat belt or unprotected sex (Pembroke 1996, Turp 2003). Self-harm as an umbrella term can take the form of behaviours or omissions, for example nail biting (self-injury), internal self-harm (eating unhealthy food) or self-neglect (not taking sufficient rest). The above, together with many other forms of self-harming behaviours can be viewed along a continuum ranging from self-care at one end of the continuum and suicide at the other end, which can also be viewed as an act of self-harm (Babiker & Arnold 1997, Turp 2003).

Building on Armando Favazza's (1987) seminal work, a cultural psychiatrist who played an important role in legitimising the study of self-harm, Turp (2003, p.37) describes behaviours that fall within the parameters of what are considered familiar and "normal" as "cashas", an acronym for culturally accepted self-harming acts or activities. These include everyday features of ordinary good enough self-care. However, the dividing line between a "cashas" from an act of self-harm is often unclear and elusive and as Turp (2003, p.36) states, in some cases "it may involve a difference of frequency or intensity rather than a difference in kind". For example, we can pull hair by plucking eyebrows, waxing bikini lines, shaving underarms all of which may be considered 'culturally acceptable', however, taken to extremes Trichotillomania the same behaviour may be considered as a compulsive disorder and considered self-harm. Babiker & Arnold (1997) argue that the point at which a particular kind of behaviour is considered to have exceeded the boundaries of what is acceptable is culturally embedded, and therefore varies between cultures, sub-

cultures, generations and individuals. Behaviours that attract the label of self-harm therefore not only include an element of self-inflicted injury but also “an element of transgression, with the breaking of unspoken cultural rules” (Turp 2003, p.31).

Deliberate self-harm (DSH), parasuicide and non-suicidal self-injury (NSSI)

Historically, the concept of deliberate self-harm arose out of Kreitman’s (1977) term ‘parasuicide’, a label which referred to all non-accidental hospital-treated self poisoning and self-injury that did not result in death, regardless of the intention of the behaviour. Over the years, the term ‘deliberate self-harm’ replaced ‘parasuicide’ and was used by the World Health Organisation (WHO) to describe a number of large-scale epidemiological studies that was undertaken in multiple sites in Europe, which may explain its popularity outside of the USA. Some suicidologists often employ the term deliberate self-harm also referred to as DSH. This term has been criticised by some writers in the field for its pejorative, accusatory overtones and as such are deemed to be insensitive and inappropriate (Babiker 1997, Pembroke 1996, Inkle 2010b). Silverman (2006) believes that such terms should be removed from this lexicon. In Europe, the current term being used to describe behaviours that do not lead to death with or without intent is self-harm, whereas in the US the term ‘non suicidal self-injury’ (NSSI) is gaining momentum to describe similar behaviours, that is, direct deliberate self-inflicted destruction of one’s own body tissue in the absence of suicidal intent and the exclusion of practices accepted as cultural norms (Favazza 1987, 2012).

Self-harm and self-injury

Self-harm and self-injury are often used interchangeably; however, it is important to understand the different meanings behind the terms. Self-injury can be described as “an intentional self-inflicted attack(s) on the body, without suicidal intent, and for purposes not socially or culturally sanctioned” (Klonsky & Muehlenkamp 2007, p.1045). Implicit in the definition of *self-harm* [*self-injury* my italics] is the understanding that the body is going to be deliberately and repeatedly harmed (Gardner 2001, Sutton 2007). Self-injury is a complex and personal experience and as stated earlier may present in various ways; the most common forms include self-cutting or self-burning, often of the arms and hands, sometimes the legs and less commonly the face. Other ways in which people injure themselves include scratching, biting, picking and occasionally inserting sharp objects under the skin.

Less common forms include tying ligatures, pulling out one’s hair and scrubbing oneself so hard (sometimes using cleansers such as bleach) as to cause abrasion (Duffy 2009). For Babiker & Arnold (1997, p.2) “self-injury is one part of a large repertoire of behaviours that *involve the body* in the expression of distress within the individual”. Figure 1 has been adapted to illustrate further details of behaviours involving harm to the body. Notwithstanding the different meanings that underlie the terms self-injury and self-harm both share a common connection, that is, they each refer to some degree of harmfulness to the body.

Figure 1. Self-injury in the context of other behaviours involving harm to the body

<p>Somatic expressions of feelings e.g. skin disorders e.g. stress eczema pain e.g. headaches, accident-proneness</p>	<p>Self-destructive behaviours e.g. eating disorders substance abuse</p>	<p>Body ‘enhancement’ e.g. waxing tattooing piercing</p>
	<p>Self-injury/ e.g. cutting, scraping burning banging and hitting</p>	<p>Self-harm e.g. suicide overdosing</p>
	<p>Other/marginal self-injurious behaviours e.g. smoking binge drinking unhealthy diet and lifestyle unprotected sex reckless driving</p>	

Source: Adapted from Babiker & Arnold (1997, p.4)

Self-harm and suicidal behaviour

As stated previously, it is now widely accepted that self-harm and suicidal behaviour differ, the key difference being that in attempted suicide the person intends to kill him/herself, in self-harm the person does not (Tantam & Whittaker 1992, Linehan *et al* 2000, Muehlenkamp 2005). As Babiker & Arnold (1997, p.2) succinctly differentiates, “self-injury continues the discourse of a person’s life, whereas a suicide attempt separates the person from the discourse, removing the individual from their awareness or from being”. Other differences grounded in empirical research, between self-harm and suicidal behaviour include lethality, methods,

cognitions, reactions, aftermath, demographics and prevalence, which according to Hawton (2000) further informs the differentiation debate. Several writers in the substantive area of self-harm argue that the term 'self-harm' itself does a disservice when in fact, a significant difference between self-harm and attempted suicide is that the person who self-harms can be said in some ways to be carrying out the "very reverse of self-destructiveness", that is, making an attempt to self-heal and/or self-care (Pembroke 1996, Babiker & Arnold 1997, p.7, Turp 2003, Inkle 2010b).

Notwithstanding this, suicide is often conflated with self-harm both in the literature and in clinical practice, whereby self-harm is viewed as an '*unsuccessful*' or '*failed suicide attempt*' and that it will lead on to a '*successful suicide*'. The nomenclature for suicidal ideation and behaviour has been the subject of considerable international attention and debate. According to Van Orden *et al* (2010) a suicide attempt should possess the following components; self-initiated, potentially injurious behaviour, presence of intent to die and non-fatal outcome. Cutcliffe & Stevenson (2008a, p.154) are critical of those who place "these two distinct phenomena as one and the same, merely at different points of a continuum of lethality" However, they together with others in the field also acknowledge that the line between suicidal and non-suicidal behaviour is often blurred in individual cases (Soloman & Farand 1996). In addition, research shows links between self-harm and an increase in the risk of suicide; sadly there is also evidence that some people who self-harm do go on to take their own lives. Furthermore, previous suicide attempts are one of the most significant predictors of completed suicide and serious suicidal ideation can be a precursor to suicidal behaviour (Zahl & Hawton 2004).

While the two behaviours - self-harm and suicidal behaviour are clearly related and share a complex relationship; fundamental differences have been well documented, therefore to conflate the two is inaccurate and misleading. However, in clinical practice differentiating between forms of self-harm and suicidal behaviour is not always clear cut. While knowing the presence or absence of intent to die is essential to distinguish a suicide attempt from self-harm (Ploderl *et al* 2011), with respect to intent, Rosenberg *et al* (1988, p.1446) cautions that "absence of evidence is not evidence of absence". In addition, Babiker & Arnold (1997, p.6) argue that during times of distress the person may have "complex, ambivalent and/or confused views of their exact intent" and consequently, the person who frequently self-harms may

also at other times harm themselves with suicidal intent and often by using different means.

Confusion still remains both within the literature and in clinical practice about what exactly constitutes suicidal behaviour. It is therefore essential to understand how suicidal behaviour is defined and operationalised. The importance of using the same terms and definition is strongly advocated and more importantly that the terminology used is easily understood, applied, and internally consistent (Silverman 2006). Notwithstanding, Silverman (2011) some years later highlights that agreeing on definitions and terminology still remains elusive, therefore establishing a standardized nomenclature continues to be a conundrum yet to be resolved in the field of suicidology. This poses challenges for both clinicians and researchers such as the use of different definitions not only contributes to imprecise and inconsistent communication, but also renders the comparison of national and international studies difficult, as well as reduces the potential for effective preventative and therapeutic interventions. Furthermore, the current nomenclature together with the interplay of previously held beliefs can reinforce the stigma associated with suicidal behaviour. As Silverman (2011, p.21) asserts “unless and until the field of suicidology speaks the same language and approaches the classification of suicidal behaviours in a clear, concise and consistent manner communication between and among all those who work for the goal of suicide prevention will remain clouded”.

The epidemiological discourse of suicide and self-harm

In recent decades, a great deal of academic endeavour, attention, financial and human resources have been directed towards the study of epidemiology and suicide. Most work has focused on determining risk of suicide and on elucidating an underlying pathology or predisposing genetic and psychological factor within individuals (Beautrais *et al* 2005). The epidemiological discourse lays the foundation for the dominance of the biomedical approach, which aligns suicide and self-harm exclusively with biological interpretations of mental illness that requires treatment. This in turn, may inadvertently remove some of the responsibility that individuals have when it comes to managing their own mental health and capacity to keep themselves safe and alive, as it places the cause within the realm of an innate biological predisposition. Research undertaken has largely used a quantitative

approach and comprised surveys, epidemiological case control studies, psychological autopsies, psychological and psychiatric treatment records and hospital charts and clinical interviews and formal experiments (Maris *et al* 2000). Much of the research that focuses on people who have attempted or completed suicide takes an epidemiological or mental health perspective. While epidemiology is concerned with distribution of disease and factors that influence distribution, suicide is a behaviour and not a disease (Cantor 2006). Nonetheless, epidemiological approaches provide the dominant discourse for the understanding of suicide and self-harm and is mostly characterised by the biomedical discourse which emphasises an illness model. Globally, suicidal and self-injurious behaviours are monitored as part of guiding and shaping government health policy with a view to developing suicide prevention strategies (Rogers 2001), also measured to help compare countries. Furthermore, it is hoped that acquiring epidemiological data on suicide rates and other variables such as age, gender or sexual orientation will provide a profile of the population and indicate if rates have been rising within certain subgroups, such as young men (Dorling & Gunnell 2003), or LGBT population (King *et al* 2008). Epidemiology also looks at methods, socio-and marital status, which will be addressed after discussing the prevalence of suicide and self-harm within an Irish context. This research is considered an important tool in the identification of factors that can help recognise individuals at risk for completed suicide and identify broad protective factors (Rogers 2001), and therefore prevent it.

Suicide is among the ten leading causes of death worldwide, accounting for approximately 1.5 million people dying by suicide each year. According to Fonagy (2008, p. xvi), suicide is one of those “rare disorders where prevalence does not follow the usual line of socioeconomic determinism”, and the risk of dying from suicide for whites is more than double that for blacks (Hoyert *et al* 2006). Over the past five decades, suicide rates have increased by 60% with young people being the highest risk group in a third of all countries (Windfuhr & Kapur 2011). Suicide is the second leading cause of adolescents’ deaths in most developed countries (Hawton & van Heeringen 2009, Oughrin 2012). Since 2009, 104 countries within the six WHO regions have reported suicide data. The highest rates of suicide are in Eastern Europe with four countries reporting suicide of over 20 per 100,000 population; Central-Southern America and eastern Mediterranean countries have the lowest rates and suicide rates in other regions Western Europe, Asia and Africa are somewhere

in-between (WHO 2010). Ireland has the sixth lowest rate of suicide in Europe, with a reported rate of 10.3 per 100,000 population compared with the lowest rate of 3.9 in Greece and the highest of 34 in Lithuania (National Office for Suicide Prevention (NOSP) 2011).

Suicide and self-harm: Irish context

As with most international studies, the epidemiological focussed studies in Ireland have attempted to determine the prevalence and distribution of suicide and therefore much work has focussed on the prevalence of suicide associated with specific variables, for example gender, and age. Similar to other western countries, in Ireland the illness model has up to now had the greatest impact on how suicide has been explained and understood. In addition, both prevention and treatment are primarily focussed on the underlying illness, primarily major depression. The Central Statistics Office (CSO) estimated 525 deaths on the island of Ireland in 2011, an increase of 3% (486) on the previous year (NSRF 2012). Suicide accounts for 1.7% of all deaths in Ireland each year (NOSP 2009). The total economic cost of suicide is estimated at around 800-900 million Euros per annum (Kennelly 2007). In the last thirty years the rate of suicide has almost doubled from 6.4 per 100,000 in 1980 to 12.4 per 100,000 in 2009 (NOSP 2010, 2011, 2012); in 1998 it was at its highest at 13.9 per 100,000. While the overall number of recorded suicides is low, the rate of youth suicide remains the fourth highest in Europe (HSE 2012). This is largely due to a notable increase in suicide affecting young men in their early 20s; the highest suicide rate for men aged 20-24 years is 29.3 per 100,000, which is significantly higher than the national average of 11.3 per 100,000. However, suicide rates are consistently high for men of all ages up to the age of 65 (NOSP 2010), the rate ranges from 18.1 for 15-19 year olds to 22.1 for 60-64 olds. Suicide is now the leading cause of death amongst males and females under the age of 35. In contrast, the overall female rate of death by suicide has not varied significantly since 1980; although there is some variation across the age groups with the highest rate seen for women aged 50-54, at 8.7 per 100,000. As such, there is still a large gender variation in suicide rates with a male/female ratio of 5 to 2:1.

Similar to other countries, non-fatal suicide acts, also known and recorded as deliberate self-harm are of concern to Irish health and social services. In 2011, The

National Registry of Deliberate Self-Harm recorded 12, 216 presentations to hospital due to deliberate self-harm, with drug overdose being the commonest method of self-harm registered involving over two-thirds (9,834) of individuals (NSRF 2012). Cutting was the only other common method of self-harm involved in all episodes. Although the female rate of DSH is higher than the male rate, differences between male and female rates have been narrowing from 37% in 2004-2005 to 13% in 2009-2010 (NOSP 2006, 2010, 2011). However, as stated earlier given the secretive nature of self-harm, many incidents are never reported and as such go unregistered. In Ireland, the classifications and under-reporting of suicide has come under much scrutiny. Prior to decriminalization, suicide was still highly stigmatised and as a result it was estimated to be under-reported by 15-20% (Kelleher 1996, Cantor *et al* 1997). Although reporting of suicide is said to have improved in recent years, Corcoran & Arensman (2010a) believe that deaths are still often misclassified, which suggest figures for suicide rates in Ireland could potentially be higher than official statistics.

Notwithstanding this, there is great variation across countries within each region that report suicide rates, and consequently there may be variations in how the data is compiled within individual countries and reported to the WHO. Furthermore as previously discussed, problems of definition, differences in procedures of ascertainment between countries and the reluctance of some countries to report suicides for example Western Pacific and Middle Eastern countries further compound the reliability of data on suicide rates. The overall picture of the different regions of the world with high and low suicide rates may therefore be misleading. In addition, given the stigma associated with suicide as a result of socio-cultural or religious factors (Lester 2006) death by suicide can be hidden and under-reported. Data concerning the rates of suicide should therefore be treated with caution (Tanney 2000). It is highly probable that figures of known suicides may be higher, which reinforces the gravity of this global and national public health phenomenon.

Suicide: Age, gender and sexual orientation

Since the 1960s, there has been a significant change in age-specific suicide rates. From the 1960s to the 1980s there was an increase in suicide among young adults; however, in the decade after there was a decline in suicide rates among 15-24 year

olds, especially males in many countries including England (Biddle *et al* 2008), Scotland (Stark *et al* 2008) and Canada (Steele & Doey 2007). Generally, suicide rates increase with advancing age in most countries (Bertolote & Fleischmann 2002), although in the last twenty years the incline is less steep and in some countries there are greater numbers of suicides among young adults, for example in Ireland (Corcoran *et al* 2003, NSRF 2010, 2011) and the UK wherein suicide numbers and rates are now highest among males aged 15-44 years (Hawton & Rodham 2006, Hawton & van Heeringen 2009). The gendered nature of suicidality is well documented in the literature. In Western countries rates of suicide in most countries are higher in males than females (WHO 2010). One exception to this gender difference is China (excluding Hong Kong) where the male: female ratio is 0.9:1 especially among young women in rural areas (Cheng & Lee 2000). In addition, while mental illness is the predominant factor found in suicides of both sexes, a growing number of studies have identified that sexual orientation and suicide is now becoming a major issue with high rates of suicide attempts among gay, bisexual (GB) men and transgender men and women (Bagley & Tremblay 2000, King *et al* 2008, Hass *et al* 2011, Chakraborty *et al* 2011, Bockting *et al* 2013, Pompili *et al* 2014).

Self-harm: Demographics, age and gender

Self-harm is usually a secretive behaviour; statistics based on reported incidents therefore do not accurately reveal prevalence estimates (Fox & Hawton 2004, Duffy 2009). In addition, the variation in rates for self-harm is also likely to be influenced by the absence of a universal definition and the use of a plethora of terms as discussed earlier. However, studies have noted that 4% of adults report a history of self-injury (Klonsky & Muehlenkamp 2007). While there is an increased prevalence of suicide among males, in contrast women engage in self-harming more frequently than men in many Western countries and higher rates were generally found among young adults. In particular, young women aged 15-24 years and young men aged 25-29 years had the highest rates of self-harm (Canetto 2008). The contrast between women's and men's self-harming and suicide completion is sometimes referred to as a "gender paradox", particularly in younger age groups (Canetto & Sakinofsky 1998).

Self-harm often reoccurs and within a short period of time. Based on hospital admitted or treated samples, the rate of repetition is approximately 15-16% within one year of an episode and rising to between 20-25% in the years thereafter (Owens *et al* 2002). Factors associated with repetition of self-harm are numerous including demographics for example, female and younger age. Most self-harm presentations to hospital generally occur outside normal working hours with females more likely to present at the weekend (Gunnell *et al* 2005). Literature on the repetition of hospital-treated self-harm comes mainly from the UK, Ireland, Nordic countries, with fewer studies from North America, Australia and New Zealand. Cooper *et al* (2005) report that individuals who have self-harmed have a 30-to 200 fold increased risk of suicide in the year following an episode compared with individuals who have not self-harmed. However, given that not all persons with episodes of self-harm seek treatment or require medical intervention, studies that focus on medically treated self-harm do not reveal the true extent of the problem and therefore underestimates the prevalence of self-harming behaviour in the wider population (Cooper *et al* 2006, Corcoran *et al* 2006). Internationally, rates of self-harm are also difficult to ascertain, mainly because the relevant data are not collected comprehensively and systematically within individual countries. Furthermore, where data is collected, comparison between locations is often difficult due to the absence of a universal definition and methodological differences for example, how self-harming behaviour is determined by the medical profession and data are recorded, as well as, where and how the data are collected for example, hospital-based studies or general population surveys /interviews.

Suicide methods

Methods of suicide include hanging, self-poisoning and jumping from a height, although the preferred methods of choice vary substantially by sex and country. Hanging is the most common method among men across nations compared with self-poisoning among women (Ajdacic-Gross *et al* 2008). However, the variability in method seems to be more influenced by country than by gender, suggesting that availability of method is an important determining factor for both male and female suicides. For example, in the US firearms are the most common method for approximately 95% of all suicide death whereas in many Asian countries for example, in Hong Kong suicide by charcoal burning has emerged as a common

method of suicide. In Ireland, hanging is the most common method among males of all age groups and in particular males and females aged 15-24 (NOSP 2012).

Given the challenges inherent in suicide classification, it is not surprising that there is a significant body of evidence concerning the limitations of suicide statistics (Classssen *et al* 2010). Suicide underreporting along with methodological limitations including sampling bias, problems of definitions, and exclusion of actively suicidal people from controlled trials have been well documented with suicidal epidemiological studies (Briggs *et al* 2008a&b). Therefore, we can only ever estimate, albeit with a small degree of empirical confidence. In addition, since most of the research is carried out in so-called Western parts of the world it is questionable whether such results can be generalised to other parts of the world. Despite the irrefutable evidence of such limited accuracy, research findings based on suicide statistics are used by epidemiologists to compare suicide rates between countries and between demographic groups over time and provide a valuable body of work.

The medical discourse of self-harm, suicide and mental illness

In the recently revised DSM-5TR (APA 2013) manual non-suicidal self-injury (NSSI) is now recognized as a distinct condition. Criteria for NSSI require five or more days of intentional self-inflicted damage to the surface of the body without suicidal intent within the past year. Clients must also engage in the self-injurious behaviour with at least one of the following expectations: to seek relief from a negative feeling or cognitive state, to resolve an interpersonal difficulty, or to induce a positive state. Hitherto, non-suicidal self-injury (NSSI) or self-harm was only listed in the DSM-IV-TR (APA 2000) as a symptom of borderline personality disorder (Klonsky *et al* 2003). Although there is evidence that that self-harm is an important symptom of borderline personality disorder; studies have also indicated that self-harm occurs across a variety of psychiatric diagnoses, as well as among people without any diagnosis. Consequently, many researchers study self-harm as a separate behavioural phenomenon, rather than as a symptom of borderline personality disorder. While there are no proven treatments, dialectical behaviour therapy (DBT) has demonstrated a reduction of self-harm episodes and hospitalizations in women with borderline personality disorder (Linehan 2000); although further research is needed to determine the extent of the efficacy of this intervention, the reasons for its

efficacy, and the degree to which it should be adopted in community mental health settings (Scheel 2000).

Although suicide is often associated as a symptom of mental illness, suicide is not characterised as an illness itself and until recently there was no diagnosis within DSM IVTR (APA) 2000 for being suicidal (Cutcliffe & Strevenson 2007). However, the revised DSM-5TR (APA 2013) manual now categorises clients who express suicidal behaviour within the past twenty-four months, but who do not qualify for another psychiatric illness, under the new diagnosis category "suicidal behaviour". In relation to suicide, the emphasis of current psychiatric thinking as applied to research and practice assumes an underlying pathology (Michel et al 2002). The illness model has up to now had the greatest impact on how suicide has been explained and understood. Notwithstanding this, although mental illness³ is consistently reported in the literature on epidemiology and aetiology of suicide it is also recognised that mental illness alone does not account for all the risk associated with suicidal behaviour. In fact, suicide or self-harm does not constitute a mental illness (Maris *et al* 2000), yet as many as 98% of those who kill themselves have a mental illness (Bertolote & Fleishman 2002). In most Western countries, mental illness and in particular mood disorders, are consistently cited as one of the key contributory factors to suicide risk (Fonagy 2008). In the EU, approximately 90% of suicides are believed to occur in the context of mental illness (Bertolote *et al* 2004). Although depression is the most common mental illness associated with suicide, other illnesses including psychosis and substance abuse have also all been linked with suicidal behaviour (Bertolote 2003). Internationally, variation in the prevalence of mental illness report higher rates in Western countries than in Asian countries. Studies from Western countries show that approximately 90-95% of people who die by suicide have a mental illness (Cavanagh *et al* 2003), whereas in Asia the prevalence of mental illness is approximately 60-90% (Vijayakumar 2004). Differences also exist with the type of mental illness among people who die by suicide in developed and developing countries. For example, more than two-thirds of people who died by suicide were reported to have a diagnosis of depressive illness in developed

³ Although I am aware of the ongoing debate around the suitability of using terms such as mental illness, disorder and distress; for consistency, I have chosen to use the term illness to reflect how the terminology is used in the literature.

countries (Mann 2002), compared with only 3%-40% in developing countries (Vijayakumar 2004).

Baldwin et al (2003) estimate that approximately 25%-40% of those who die by suicide have been in contact with mental health services in the year before their death. High-risk periods for suicide have also been identified and include during hospitalization that is, while in hospital including on leave or when absent without leave, as well as during the period immediately after discharge from hospital (O'Sullivan 2005, Qin & Nordentoft 2005). Studies investigating contact with mental health services prior to suicide have been carried out mainly in the USA, Nordic countries and the UK. However, contact with mental health services, including in-patient and community-based is likely to be different in developing countries, making it difficult to compare in-patient suicide rates and trends with other countries. Rates and characteristics of suicide among people vary by age, sex gender orientation and diagnosis.

The relationship between suicide and mental illness is complex, with higher rates of completed and attempted suicides in those diagnosed with mental illness and with different associations between suicide and diagnosis (Tanney 2000). Notwithstanding the strong relationship between suicide and mental illness in Western countries, the majority of people who think about suicide may not necessarily meet the criteria for mental illness or come into contact with formal mental health services. Having a diagnosis of mental illness is therefore not a cause of suicide. Furthermore, the risk of suicide is also associated with many other factors ranging from variables such as unemployment, to individual demographic characteristics such as gender, age, sexual orientation, marital status along with a wide range of social and psychological variables for example, the individual's social support and coping mechanisms. In addition, certain environmental variables at the time of the suicide attempt are also associated with increased risk, such as, the presence of or easy access to lethal means, for example medication.

The biological discourse of suicide

Genetics and serotonin activity

The biological discourse focuses on genetic and neurobiological risk factors may also be important in predisposition to suicide. From a biological discourse, there is growing evidence to suggest that a predisposition to suicide is at least partly genetic. The study of a genetic component to suicidality tends to consider family history, twin and adoption studies (Mann & Currier 2007). Data from adoption studies show that rates are higher in the biological relatives of adopted children who end their life compared with the biological relatives of adopted children who do not do so (Mann 2002), although again there is a dearth of international research. While a family history of suicide significantly increases suicide risk (Qin *et al* 2003), familial suicidal behaviour may also be explained by an increased genetic predisposition to mental health problems rather than suicide and self-harm specifically (Nock *et al.* 2012). This raises the question whether the social taboo of suicide is broken or that it is a learned response as opposed to being genetic. Nonetheless, adoption studies provide some evidence to suggest that the incidence of suicide among adoptees supported a genetic effect (Brent & Mann 2005).

According to Pandey (2013) the majority of biological research has focussed on the role of the neurotransmitter serotonin, although other neurotransmitters are also been widely implicated to be involved. Serotonin is believed to contribute to how we feel on an affective level (mood). According to Opacka-Juffry (2008) alterations in serotonin levels are widely accepted to impact negatively on mood resulting in depression and low mood. Consequently, an untreated episode of major depression is an important risk factor for attempted and completed suicide (Rihmer 2011). Notwithstanding this, serotonin's mode of action and its role in contributing to depression, suicide and self-harm is complex and not fully understood. Furthermore, although depression is a very common phenomenon, many people who die from suicide are not known to be clinically depressed, supporting the argument that other factors within the psychological and socio-cultural domains are important determinants in the decision to engage in self-harm or attempt suicide. In relation to self-harm, McGough (2012) suggests that the release of endorphins and adrenaline when the skin is cut may contribute to a sense of pleasure or excitement consequently perpetuating its use. Aligning suicide and self-harm exclusively with

biological interpretations of mental illness is challenged by many as it is a complex multivariate with no single theory being able to explain sufficiently such behaviours. Nonetheless, doing so may it may inadvertently remove some of the responsibility that individuals have when it comes to managing their own mental health and safety.

The psychological discourse of suicide and self-harm

Alongside the biological discourse, suicide is open to various psychological explanations. Since the 1900s, several psychological theories besides Freud's, have attempted to understand the complicated human act of suicide. According to Shneidman (1985), a psychological theory regarding suicide should start with identifying the most common dimensions or characteristics, which will then provide a meaningful conceptualization regarding suicide. Very often, external causes such as ill health, loss of job, relationship or finances are identified as common factors in suicide. However, while situational aspects are usually present in every suicidal act, such characteristics are only the precipitating events. Suicide is more complex and is a multi-determined event. As Leenaars (2004, p.17) summarises "it is an intrapsychic drama on an interpersonal stage". Viewed from this psychological lens, key ideas of the following dominant perspectives will be presented; psychoanalytical (Freud), cognitive behavioural (Beck), and multidimensional (Shneidman).

Psychoanalytical perspective

From a psychoanalytical perspective suicide is driven by unconscious intentions, even if the person communicates that he/she has consciously planned suicide, the focus of the action is in the unconscious. Current psychoanalytical thinking is underpinned by the work of Sigmund Freud, who formulated the first formal psychological theory in the 20th century about the mental processes that underlie self-destruction. Unlike Durkheim, Freud never wrote a paper specifically about suicide, yet he was often preoccupied with suicidality; all but one of his case histories (Little Hans) refer to some aspect of suicide and one of his patients⁴ died by suicide in 1898. Freud also threatened suicide at least once, writing that he would kill himself if he should lose his fiancée Martha Bernays (Maltsberger & Weinberg 2006). According to Freud suicide was essentially in the mind. His seminal paper 'Mourning and Melancholia' (1917) explored his early thinking on the dynamics of depression, in

⁴ The term patient is used in keeping with the language used in psychoanalytic literature

particular he was concerned with comparing severe depression with the normal experience of mourning following loss. Central to this paper is the idea of ‘turning against the self in hatred’, which marked a turning point in the development of psychoanalytical theory and the beginning of a theory of the internal world of the suicidal person (Briggs 2010).

Freud’s contribution was the starting point for thinking about “suicidal relatedness” (Briggs *et al* 2008a, p.3). He observed that in melancholic states, the patient berated himself with various criticisms for example, accusations of worthlessness. He suggested that if one listened carefully to these recriminations, one could see that they often fitted not the patient himself but someone else whom “the patient loves, has loved or should love” (Freud 1917, p.248). In his formulation, the suicidal act arises from the reaction to the loss of an ambivalently loved and hated object, with whom the self has identified. As such, the suicidal person is in some direct or indirect way identifying with a rejecting or lost person and has both affectional and hostile feelings towards a lost/rejecting person (object). The ego now identified with the lost object is now the target of all the hatred accusation that belonged originally to the object. Underlying all suicide and similar acts of self-destruction, there is an attack upon the self that is a self-identified with a hated object. As Freud (1917, p.252) stated “the ego can only kill itself only if.....it can treat itself as an object”. Although Freud appears to be referring to an actual loss of a current external figure, it subsequently became clear that in melancholia it is all previous losses that are activated, that is, the losses a person encounters as part of development, essentially the loss of the primary object - the mother and all that she represents (Bell 2008). Freud placed the focus of responsibility on the person that is, in the person’s unconscious and eschewed the two popular notions about suicide at the time, that is, sin and crime.

Since Freud’s formulation of suicide as anger turned back upon the self, several authors have taken up the aspect of suicide as internalised anger. Karl Menninger an American psychiatrist, outlined the psychodynamics of hostility in his seminal text ‘Man against Himself’ (1938), and asserted that the hostile drive in suicide comprises three desires: the wish to kill, the wish to be killed and the wish to die. Although Freud’s formulation of suicide began an important exploration of suicidal dynamics and remains an integral part in understanding the constellation of suicidal

relatedness; Goldblatt (2008, p.95) points out that it has been over simplified and over used, and has become ‘the cliché of suicide’ with limited clinical value in practice. Since then, more contemporary psychoanalysts through theory generated by clinical experiences, have subsequently extended, elaborated and deepened its understanding of the relational and emotional qualities of suicidal states of mind and actions (Briggs 2010). Hale (2008) summarises it as follows:

“Suicide is an act with meaning and purpose, both manifest and unconscious. It takes place in a dyadic relationship, or rather its failure, and the suffering is experienced by the survivors, or rather, part survivors of the suicide attempt” (p.1).

More current writers focus on a relational approach, which takes account of both the internal and external world of the individual and therefore supports the exploration of the interrelationship created by the merger of the intra, inter-and-extra psychic worlds (Mc Andrew & Warne 2010). Understanding different constellations of suicidal dynamics has led to the development of models of suicidal relatedness. In North America, Maltzberger & Buie (1980) identified distinctive ‘suicidal fantasies’ that is, patterns of unconscious dyadic relational dynamics that fuel suicidal behaviour. In the UK, Campbell & Hale (1991) have further developed this concept to the description of dynamics of merger (or reunion/rebirth), punishment, revenge, elimination and dicing with death. The starting point for suicide is the core complex relationship as described by Glasser (1979), which refers to a way of relating to the ‘significant other’. Glasser’s (1979) core complex relationship applied by Campbell and Hale in their formulations of suicide fantasies captures the dilemma for those patients for whom neither separateness nor intimacy is possible. For example, the former stirs terror of abandonment, that is being left by the other whereas the latter stirs fears of closeness, because with intimacy comes the fear of being engulfed by the other and losing one’s own identity. In such cases suicide appears to be the ‘solution’, based on an unrealistic appraisal of the dynamic impact of suicide on the self, particularly, the apparently delusional sense that the self’s body death can be survived (Hale 2008). In contrast to others in the field, Hale (2008) has consistently maintained that the motivation for suicide and ‘parasuicide’ (self-harm) is the same and that the only difference is the outcome; suicide is either completed, or not.

Cognitive behavioural perspective

Cognitive behavioural theory (CBT) and approaches associated with Aaron Beck and colleagues, for example Albert Ellis have also made a considerable contribution to the understanding and treatment of suicide. As a focussed psychotherapy, CBT is widely used for the treatment of depression and hopelessness. Based on the premise that our thoughts (cognitions) influence our feelings (affect) and our actions (behaviours), and interact with each other; when people hold constrictive, negative beliefs about themselves or their experiences, an emotional response or upset is likely to occur (Westbrook *et al* 2007). If the negative thinking is extreme or persistent it is likely to lead to emotional disorder such as depression and hopelessness. Once a person is depressed a set of cognitive distortions known as the cognitive triad (negative view of self, the world and the future) exerts a general influence over the person's everyday life (Beck 1976). If the person continues to have unrealistic and pervasive negative views of his/her future and cannot see the situation improving, it is likely to get worse. Behavioural factors will also serve to exacerbate the depression, for example reduced activity, lack of stimulation, withdrawal from life. Beck identified 'logical errors' that characterise the thinking in depression such as; self-blame, low self-esteem, self-worth, self-criticism are all compounded by interpreting events in a negative way. Other distortions of thinking may include magnification (catastrophising) of minor problems, over-generalization and personalisation. From this constricted view of themselves and their position in the world, together with a sense of hopelessness, the person may subsequently consider suicide as the only plausible solution to their hopeless position. Suicide is therefore thought of as a relief or escape from the intolerable pain and is considered a more desirable option than the continued struggle to live.

Building on the different perspectives within psychology that views escape as central to understanding suicidal behaviour (O'Connor 2003), the cry of pain hypothesis (Williams 1997, 2001; Williams & Pollock 2001) is a psychological model of suicidal behaviour that extends existing theories of escape (Baumeister 1990) and arrested flight (Gilbert & Allan 1998). Shifting the focus from depression to suicidal behaviour, Williams and Pollock (2001) argued that suicidal behaviour should be seen as a cry of pain rather than the traditional view of suicide as a *cry for help*. The *cry* is only secondarily an attempt to bring help, although this may be an important incidental consequence. Consistent with the arrested flight phenomenon,

Williams and Pollock (2001) proposed that suicidal behaviour is reactive, the response (the cry) to a situation that has three components: defeat, no escape and no rescue.

For the suicidal person, feelings of being defeated can arise from external circumstances, for example poor relationships, loss of job or position or from uncontrollable inner turmoil. Such stress signals to the individual that he/she is defeated in some important aspect of his/her life and activates primitive psychobiological mechanisms. The trigger point whereby the person feels a full-blown defeat and is likely to give up comprises not only a sense of being trapped in the situation, but also the belief that there is appears to be no possibility of escape or rescue from the things that are most disturbing. Suicide is the ultimate exit or escape from intolerable psychological pain (Williams 1997, 2001; Williams & Pollock 2001). The 'cry of pain' model emphasises the aspects of the person and his/her circumstances and the reactive element of suicidal behaviour (the way in which it is elicited by a certain combination of circumstances, rather than its communicative element). The behaviour is not motivated by or dependent on its consequences.

Multi-dimensional view of suicide

Shneidman (1985, 1993) advocated a multidimensional view of suicide. For Schneidman, psychological pain or *psychache* is the centre of suicide. This unbearable pain in the person's mind is pervasive; it occupies the entire person's awareness and has no foreseeable end point. It results from unmet or unfulfilled needs and is experienced as a significantly traumatic event. However, suicide is not only a reaction to unmet needs but also "the need for psychological freedoms", such as freedom from pain, guilt, shame and rejection (Shneidman 1993, p.22). Suicide involves not only the pain that is generating intense suffering but the individual's unwillingness to tolerate that pain and his/her decision not to endure it and stop it. This means that suicide also has to do with different individual thresholds for enduring psychological pain. The central issue in suicide is not death or killing; suicide is purposeful, its intention is to seek a solution to a perceived crisis and to be free of intolerable pain, which unfortunately by its very act entails the stopping of life. As Shneidman (1993, p.22) concludes, "there are many pointless deaths but never a needless death" He argues that to understand what a suicide is about, one must know the psychological problems it was intended to resolve. Critical of

epidemiological efforts to relate or to correlate suicide with simplistic non-psychological variables such as gender or some sets of nosological boxes, for example depression, Schneidman argued that both ignored the key variable related to suicide that is, intolerable psychological pain – psychache. He believed that suicide is best understood in terms of two general personality functioning; perturbation (disturbance) and lethality (deathfully suicidal). Similar to cognitive-behaviour theories, the suicidal person’s affect and thinking is constricted; feelings of hopelessness and helpless give rise to a heightened sense of disturbance (perturbation).

The sociological discourse of suicide

As Freud fathered psychological explanations of suicide, Durkheim recognised as the ‘father of sociology’ detailed the sociology of suicide and identified the social factors that lead to suicide. Although the focus in suicidology is most often the individual, suicide takes place in social and cultural contexts. Durkheim’s study on suicide – ‘Le Suicide’ 1897 and re-published in English in 1951 has been recognised for its seminal contribution and considered as the beginning of formal study of suicide. Durkheim’s theory of suicide warns that one of the major reasons people kill themselves is through lack of integration into the dominant culture. According to Durkheim, there was a causal relationship between the degree of integration in society and the suicide rate; that is, suicide should be explained as social phenomenon, rather than merely an individual act. Unlike Freud, who placed the focus of responsibility back to the individual, Durkheim’s primary aim was to explain how individual pathology was a function of social dynamics. Durkheim believed that society comprised what he called a social milieu where external forces influenced the actions and behaviours on the individuals within it. Within the social milieu, different people operated at different levels of social integration. Durkheim theorised that the underlying reason for suicide rates, for the most part, related to the level of social integration to the group (Berkman *et al* 2000). Durkheim (2002//1987) described four basic types of suicide – egoistic, altruistic, anomie and fatalistic; each was characteristic of either modern urban societies or rural non-industrial societies. These are briefly explained in Figure 2.

Figure 2. Four Types of Suicide – Durkheim

Modern Societies	
Egoistic Suicide: These occur because	Anomic Suicide: These occur during

<p>individuals have fewer ties with his/her community and shut off from other human beings and consequently have lower levels of social integration.</p>	<p>times of major change as a condition of low social integration resulting in the individual feeling estranged from usual ties and society and a result is suddenly shattered or disrupted. For example divorce, the shocking, immediate loss of a job or the death of a close friend or the loss of a fortune is thought sufficient to precipitate anomie.</p>
<p>Pre-industrial or traditional Societies</p>	
<p>Altruistic Suicide: These are marked by cultural approval and benefit the social order, they occur for the greater good where individuals ‘sacrifice’ themselves for society. In contrast, this results from high levels of social integration and may stem from great loyalty, or identification with the rules and mores in a society. The ‘altruistic’ suicide is literally required by the individual’s society wherein the customs or rules of the group demand suicide under certain circumstances. For example, suttee in India; hara-kiri in Japan; in such instances, the person acted as though he/she had little choice. Self-inflicted death is perceived as honourable.</p>	<p>Fatalistic Suicide: These occur in societies that are much regulated where the individual sees no other way to escape except by killing themselves.</p>

Source: Adapted from Hyde *et al* (2004, p.21)

The concept of ‘anomie’ is of particular relevance; according to Thompson (2006, p.424) anomie was “Durkheim’s term for the condition of modern society in which there were too few moral regulations as guides”. This type of suicide defined by Durkheim is related to large-scale societal change or crises of an economic or political nature often occurring during times of rapid change. In these situations the rules and regulations governing a society are weakened and at the same time levels of social integration similarly erode resulting in higher levels of suicide (Fincham *et al.* 2011). Alternatively, society can be in a state of constant state and anomie emerges in response to constant change and the lack of stability in a modern world (Besnard 1988).

Notwithstanding its valuable contribution, Durkheim’s work, which interestingly included the use of qualitative approaches, has not lacked its critics. Criticism directed at the theoretical framework, methodology and data has been well established within the sociological discipline (Stack 2004). Nonetheless, over a

hundred years after his theory on suicide was written, Durkheim's work re-emerges with great relevance today in terms of how suicide is understood from a sociological perspective. As stated earlier, Durkheim's theory highlighted how social integration can be disrupted by factors related to the current global economic downturn, which consequently have an impact on suicide rates. Following on Durkheim's seminal work on suicide, sociological research has given Durkheim continued support. Many authors have added to the body of knowledge concerning social determinants of health and wellness illness and how individuals' social circumstances are influential and can contribute to suicide and self-harm, for example, poverty, education, access to healthcare.

Suicide: Socio-economic and marital status

Historically, periods of economic uncertainty have been associated with rises in suicide (Durkheim 1952). According to Durkheim key societal forces such as social integration can be disrupted by factors related to economic downturn and consequently have an impact on suicide rates. Unemployment a significant societal force has been strongly associated with suicide (Platt & Hawton 2000). Over the past three decades, research has examined how economic crisis affect mortality rates within 26 countries in Europe. A large cross-national longitudinal study of 26 European countries from 1970-2007 examined the association between economic recession (in particular unemployment) and mortality rates (Stuckler *et al* 2009). The study reported that rapid rises in unemployment experienced during a recession were associated with the short-term rises in suicide among both males and females, although there were differences in the magnitude of the association across countries. With the recent global economic downturn, the association between unemployment and the increase in suicide rates particularly among working age males in the 25-35 age bracket has received considerable attention both nationally and internationally. In the UK, Greece, USA and much of Europe a series of studies reported increases in suicides following the 2008 economic recession (Kentikelenis *et al* 2011, Barr *et al* 2012, Reeves *et al* 2012). Similarly, in Ireland the economic downturn that began at the same time has been identified as a contributing factor behind the recent increase in mental health distress and suicide rates especially among males and in particular younger males in the 25-35 age bracket (Kenny 2011).

However, whether the unemployment–suicide relationship at the individual level is causal or is actually confounded by ‘health selection’, that is, poorer health or mental health leading to suicide as well as unemployment continues to be debated and the evidence remains equivocal (Agerbo 2003, 2005, Preti 2003). Higher suicide rates should therefore be treated with caution until more robust longitudinal follow-up studies are available to provide convincing evidence and to elucidate why people who become unemployed at times of recession are at an increased risk. However, while conducting such studies is essential; they are labour intensive and time consuming (Chen *et al* 2010).

Marital status and its association with suicide have been examined in several countries. Suicide is generally more common among those who are single, divorced or widowed (Heikkinen *et al* 1995). Generally, marriage offers a protective effect particularly for women, with widowhood increasing the risk in older individuals (O’Reilly *et al* 2008). For those who are separated, particularly young males, the risk of suicide has also been shown to be even greater compared with individuals who are divorced (Wyder *et al* 2009). However, there are international variations in the pattern of association between suicide and marital status for example; Yeh *et al* (2008) found in Taiwan that young married women have an elevated risk of suicide, while older widowed women had a decreased risk. Children have also been found to present a protective effect on their parents, in particular the effect is more pronounced for women than for men (Qin *et al* 2003).

Suicide and religion

Suicide occurs in every culture; it is a universal phenomenon and is not unique to the Western developed world. Although no culture or country is without suicide; it is difficult to know the extent of the problem due to problems of definition as discussed earlier in this chapter coupled with the non-existence of reliable suicide statistics for all parts of the world. Research conducted in this area has been assessed through several narrative reviews; however, the findings are mixed but tend to support the generally assumed view that religion helps to provide protection against suicide risk (Stack & Kposowa 2011). Notwithstanding, Boyd & Chung (2012) advises since most of the research is conducted in the so-called Western part of the world, caution is advised against the dangers and limitations of transposing research findings from one country to another.

The relationship between religion and mental health is complex since religion can be viewed in terms of behaviours, sets of values and beliefs, all of which can influence attitudes held about suicide (Domino & Miller 1992). Historically, the possible relationship between religion and suicide can be traced back as far back as Durkheim's 1897 thesis over a century ago. According to Durkheim religious integration, the number of shared beliefs and practices within a religious denomination influences the rate of suicide. Therefore, higher levels of integration in a particular affiliation contribute to individuals adhering to collectivistic values thereby decreasing suicide rates. Durkheim attributed the higher suicide rates among Protestant individuals as compared to Catholics, to the lower levels of integration in the Protestant religion. However, his thesis has been criticized for inconsistent findings related to religious integration and for attributing differences in suicide rates solely to varying levels of social integration (Stack 2000). Furthermore, as Domino & Miller (1992) argue it is not the religion that lowers the risk of suicide but the social support that people gain from engaging and participating in and outside of the church congregation and religious affiliations. Domino (2005) points out that it is unlikely that religion is a singular mechanism and not all religious groups have homogenous attitudes towards suicide. Most religions have explicit prohibitions against suicide⁵. In Ireland a predominantly Catholic country, prior to the decriminalizing of suicide in 1993 burials of persons who died by suicide did not have a Catholic funeral mass or burial in consecrated grounds.

⁵ Judaism; refers to Leviticus 19:14. Suicides are frowned upon and buried in a separate part of a Jewish cemetery, and may not receive certain mourning rites. In actual practice, every means is used to excuse suicide—usually by determining either that the suicide itself proves that the person was not in their right mind, or that the suicide must have repented after performing the deadly act but shortly before death occurred.

Catholicism; cites the 5th Commandment - 'Thou shalt not kill' as mandating that one's body belongs to God. Suicide is viewed as a sin according to the theology of Canon Law (Roman Catholic Church). The Catechism of the Catholic Church, Paragraph 2282 also points out that, "Grave psychological disturbances, anguish, or grave fear of hardship, suffering, or torture can diminish the responsibility of the one committing suicide. The Catholic Church use to practice that persons committing suicide could not have a Catholic funeral mass and burial. This practice has since changed.

Conservative Protestant faiths; believe suicide is self-murder, while liberal Protestants generally believe one can be forgiven if she/he has faith in Christ. Conservative Protestants have often argued that because suicide involves self-murder, then anyone who commits it is sinning and is the same as if the person murdered another human being.

Islam; views suicide as one of the greatest sins and detrimental to one's spiritual journey and has strict prohibitions at 4:29 and 2:195 of the Quran (Koran) and Hadith (Sahih Bukhari vol 2, book 23, number 4460).

Hinduism; suicide is spiritually unacceptable. Committing suicide is considered a violation of the code of ahimsa (non-violence) and therefore equally sinful as murdering another.

Buddhism; does not condemn suicide, but rather states that the first principle is to refrain from the destruction of life, including one's own.

Summary and conclusion

In summary, this chapter explored the various discourses that have shaped and informed our understanding of suicide and suicidal behaviour, albeit with a distinct bias towards a western culture model. Over the last century or more and interestingly in the absence of a universally accepted and agreed definition of suicide, numerous theoretical discourses have emerged and evolved to explain suicide. While each discourse helps to unravel the complexity of motive for suicide, all conceptual frameworks are undermined by their failure to do so conclusively. Consequently, despite extensive efforts over recent decades no one theoretical interpretation on its own can provide a single explanation for all the variants documented in suicide. Nonetheless, acknowledging the methodological and epistemological limitations of epidemiological studies of suicide, the national and global data that highlights the increasing suicide trend cannot be ignored. While the causal factors contributing to suicide are many and complex; persons with mental illness or a psychiatric diagnosis invariably depression are considered a high-risk group. In order to attempt to fully understand what it means to be suicidal and how it feels for the person, demands a biopsychosocial perspective of suicide and the need for methodological pluralism within suicidology, and at the same time the acknowledgement and acceptance for an interdisciplinary approach to understanding suicide. However, within the different hierarchical positions of the various discourses, the biomedical discourse takes a dominant place. The heavy reliance on particular ways of understanding the relationship between mental illness and suicidality may mean that few alternative understandings are available to the person experiencing a suicidal crisis. Moreover, the context from which the concept of suicide is framed and understood is likely to exert an enduring influence on how professionals including mental health nurses think about suicide as well as influence how they decide upon what interventions and strategies will be used to guide their clinical work with the suicidal person. Against this background and given that mental health nursing sits within the biomedical discourse, it is therefore inevitable that it will influence and shape how nurses make sense of suicidal behaviour and how they respond to and work with clients.

In conclusion, the exploration of the history of the changing ideas around suicidality presented in this chapter suggests that explanations of suicide and attitudes to and rationales for suicide are highly dynamic and contextual. Suicidality is not an objective fact or a 'constant' (Foucault 1985, p.4). As a concept, there is no single definition of suicide; instead there are several discourses; each of which has provided

a set of boundaries that have shaped our understanding of suicidality at a particular historical period and within a western culture.

The next chapter will explore the literature on suicidality in the context of mental health nursing and people experiencing suicidal thoughts and behaviours.

Chapter Three: Suicide – Mental Health Nursing Discourse

Introduction

The previous chapter focussed on the various discourses that have influenced and shaped our understanding of suicidality. This chapter draws on a range of literature and empirical research from mental health nursing to provide the reader with an overview of the current state of knowledge in the area of clinical practice. The chapter is divided into three sections. Firstly, I will present research on the care of the suicidal person from the dimension of mental health nurses' and clients' responses. This will be followed by an account of the research on the dominant interventions applied by nurses when caring for suicidal clients. In the final section

of the chapter, a summary of the research in the area of suicidality as it relates to nurses' responses to the death of a client through suicide will be included.

Although mental health nurses regularly come into contact with people at risk of suicide, there is a dearth of research in this substantive area undertaken by or referring specifically to mental health nurses. The research that exists comprises predominantly qualitative studies of nurses' accounts of caring for suicidal clients primarily in in-patient mental health settings and mainly in Europe. With limited Irish studies available, the literature emanates from research conducted in the UK, Northern Ireland, Sweden, Norway, Korea and Australia.

Caring for the suicidal person

Historically, mental health nurses as front-line carers for people who are suicidal, play an important role in helping people recover from suicidal crisis in a range of hospital and community settings, including the client's home. The people with whom mental health nurses work with are at a heightened risk of suicide relative to the general population (Luoma *et al* 2002, Nock *et al* 2008). While globally there is significant variation in mental health services, the increasing shift both nationally and internationally towards delivering mental health nursing services in the community has meant that caring for the suicidal person is not limited to in-patient care (Simpson 2005, McArdle 2008, Happell *et al* 2012). For those working in mental health services including mental health nurses, suicide prevention is obviously a priority. Carrigan (1994) along with Cutcliffe & Stevenson (2008b) some years later, argue that the care provided by mental health nurses can help to prevent death as well as assist recovery from suicidal crisis. However, evidence suggests that there is dissatisfaction with the quality of care provided from both clients' and nurses' perspectives. Research about care of the suicidal person will be presented from both perspectives.

Caring for the suicidal person: Nurses' responses

There is overall consensus among nurse researchers in suicidality that the ability to engage and communicate with people who are expressing suicidal thoughts or behaviours is paramount to maintaining and promoting the person's safety and well-being, and at the same time to help alleviate the person's distress (Carlen &

Bengtsson 2007, Cutcliffe & Stevenson 2007). Furthermore, Samuelsson *et al* (2000) assert that such therapeutic discussions support the process of recovery for the client during and post a suicide crisis. Several studies examining nurses' role in providing care for the suicidal client reported that mental health nurses played an active supportive role for clients with suicidal behaviour by means of listening and counselling (Duffy 1995, Long & Reid 1996, Talseth *et al* 1997). However, studies with a client perspective reported that clients' need to communicate their suffering was not always met by nurses (Samuelsson *et al* 2000, Talseth *et al* 1999, Lees *et al* 2014). This is not only likely to have a detrimental impact on the person's mental health (Hawton & van Heeringen, 2009) but also discourage people at risk of suicide to ask for help or disclose how they are feeling.

In order to care for suicidal clients, mental health nurses need to be able to communicate openness and acceptance of each client's feelings and life situation at that time (Cleary *et al* 1999, Samuelsson *et al* 2000, Talseth *et al* 1997, Wiklander *et al* 2003, Cutcliffe *et al* 2006). However, suicide is a complex, emotional and difficult topic that produces a wide range of beliefs and responses from people, which are likely to be present in their therapeutic/helping interactions (Reeves 2012). Negative or hostile responses by professional care givers including mental health nurses, can undermine the commitment shown to helping the client and cause the person to feel that the worker or mental health nurse is unsympathetic, unconcerned and uncaring (Thompson *et al*, 2008). Consequently, Davidhizar & Vance's (1993) albeit dated case study of nurses in a mental health unit reported that it is important for mental health nurses to be aware of their beliefs and feelings about suicide, so that they can engage and communicate therapeutically with the suicidal person, and to ensure that they do not distance themselves from the client. Although interpersonal engagement between nurses and suicidal clients is reported as essential, nursing research indicates that nurses often struggle when confronted with client suicidality and there is evidence of unfavourable attitudes and unhelpful encounters among nursing personnel (Talseth *et al* 1999, 2001) coupled with the lack of therapeutic engagement from the perspectives of clients and nurses (Lees *et al* 2014).

Nurses' emotional responses

Working with the suicidal person evokes a wide range of feelings, which often occur at the same time. For many nurses, the presence of a discussion about suicide can be

experienced as challenging (Gilje *et al* 2005, Carlen & Bentsson 2007). Nearly twenty years old, Long & Reed's (1996) survey of nurses (N=50) working in acute admission reported that a large number (82%) found caring for suicidal client as very challenging, although at the same time, they viewed caring for the suicidal person as a very positive experience after the initial distress. Few studies indicate whether such nurses' responses are influenced by either experience or further education or both. However, Samuelsson *et al's* (1997) Swedish study using an attitude and visual analogue revealed that older nurses and those with more frequent contact with suicidal clients and possible more life experience had more positive attitudes towards caring for this client group. Gijbles (2003) conducted a qualitative study in an English Health Trust with fifteen community psychiatric nurses (CPNs) that explored their practices with people considered to be at risk of suicide. He developed a conceptual framework, 'accommodating uncertainty', which describes and explains the CPNs' actions and interactions (assessing, judging, deciding and intervening), and the complex intricate interplay of factors, which impact of those actions and interactions. His study reported that the CPNs and other professional colleagues across disciplines experienced a range of disparate responses to suicide attempts, ranging from shock, pain, guilt and anger to surprise and acceptance. Some years later, Talseth & Gilje (2011) reported similar emotional responses experienced by nurses when caring for a person who is suicidal included anger, fear, sadness, grief and frustration or helplessness. Such emotional responses not only impact on how mental health nurses engage with the suicidal client but also, the extent to which they are willing and/or able to talk and explore with the client his/her thoughts and behaviours.

Nurses' therapeutic engagement

Similar to any therapeutic/helping relationship, the relationship between the mental health nurse and the suicidal person is paramount (Cutcliffe & Stevenson 2007). One of the most important factors in preventing suicide is the presence of a supportive human resource (Beautrais *et al* 2005) and in particular, the depth and quality of the therapeutic relationship. The person at risk of suicide needs someone to connect with, particularly at the time when their feelings of hopelessness are strong (Cutcliffe & Stevenson 2007). In such instances, the person is likely to seek out and approach a mental health nurse whom they trust and feel able to connect with in some way. In fact, in the context of helping, suicidal persons have a well-tuned radar, which can

detect the extent of a helper's interest (Royal College of Psychiatrists 2010). Having a positive attitude towards those who engage in suicidal behaviour is therefore crucial to achieving any meaningful engagement and interaction. Given that suicidal clients often experience ambivalence towards living or dying (Bertolote *et al* 2004) an interaction without engagement can increase the risk for suicide both during hospitalisation and after discharge (Samuelsson *et al* 2000, Talseth *et al* 2001). However, despite this knowledge, unhelpful and unsatisfactory interactions are experienced and described by people experiencing suicidal thoughts and behaviours.

Exploring with the client the meaning of their suicidal thoughts and behaviours requires the mental health nurse not only to be able to connect with the person, but also to demonstrate a willingness and ability to develop and remain connected with the person at risk. Throughout the literature, the importance of therapeutic engagement as an essential need in practice is recognised by both nurse and client data (Talseth *et al* 1999, Gilje *et al* 2005, Cutcliffe *et al* 2006, Gordon *et al* 2011). A recent mixed method study conducted in Australia of both mental health nurses in in-patient services and clients who had recovered from a suicidal crisis reported that nurses considered therapeutic engagement to constitute skills of active listening, empathy, establishing trust and rapport (Lees *et al* 2014). They also found that while some degree of therapeutic engagement is experienced by clients and nurses, therapeutic engagement is not always prioritised or carried out to the extent that is possible by nurses. Furthermore, the limited interpersonal engagement was also reported to limit the therapeutic potential of the dominant interventions such as special observations and discussed later, could compound the client's sense of isolation and withdrawal. Similar findings were reported in earlier studies, which highlighted the different ways and approaches used by nurses while engaging with suicidal clients (Talseth *et al* 1997, 1999).

Talseth *et al's* (1997) Norwegian phenomenological study of nurses' relationships with suicidal clients in in-patient setting identified two types of therapeutic engagement between two extremes – 'distance' and 'closeness'. A 'distant' relationship with clients meant that nurses' relationships were guided by compassion without emotional identification with the client's situation and experience at that time. Instead, the nurse-client relationship was guided by nurses' knowledge of diseases and principles of treatment. Nurses felt responsible for client's suicide and

attempted suicides and felt guilty. In addition, they did not engage in exploring with the client the meaning of their suicidal thoughts and behaviours and therefore avoided engaging or understanding the client's anxiety and despair. Although they had contact with clients who did not respond to their help, they felt incompetent, helpless and unable to help in the way that they wanted. In contrast, having a 'closeness' relationship with clients involved nurse giving their full attention by listening to clients' needs and their supports in order to help the client talk about their thoughts and feelings. For the nurses, this also meant being aware of their own feelings, such as sadness, despair and having the ability to contain such emotions when working with clients who are expressing suicidality. Consequently, nurses were able to convey a sense of confidence and belief in the client's ability to be responsible for their own safety and recovery.

A few years later and as part of their earlier study, Talseth *et al* (1999) also studied clients' lived-experiences of their contact with nurses in-patient settings. This study confirmed their earlier findings about the different ways nurses engaged with suicidal clients that is, from positions of 'distance' or 'closeness'. More worrying, this study also highlighted the impact of the different types of engagement for suicidal clients. The two main themes identified comprised of 'confirming' and lack of 'confirming'. From the perspective of clients, being confirmed by nurses meant that they felt nurses were interested in them as a person and beyond their symptoms; nurses also listened and demonstrated caring in their attitudes towards them. Consequently, this helped to convey a sense of hope to clients. In contrast, 'lack of confirmation' by nurses meant clients felt that nurses listened to them with prejudice, which implied that they were only concerned about their symptoms and the effects of medication. Consequently, they felt their feelings were ignored. For some clients, this had serious implications in that it reinforced their sense of hopelessness and they began to consider ways of ending their own lives (Larsson *et al* 2007, Ghio *et al* 2011, Lees *et al* 2014).

Labelling clients' suicidal behaviour

Carlen & Bengtsson (2007) also found that nurses emotionally distanced themselves by categorising clients into different groups or identities including psychiatric diagnosis. They found that labelling clients provided nurses with an explanation and understanding for the client's responses to them and why they might find it difficult

to care for the client or be certain about the client's potential risk of suicide. According to Rodgers & Cowles (1997), labelling or objectifying the client also serves the function of concealing the client's suffering. Emotional distancing may therefore be a strategy to minimise or dismiss consciously or unconsciously painful emotions that are present when caring for clients with suicidal behaviours. In a similar vein, Joyce & Wallbridge (2003) posits that emotional distancing may help nurses to deal with their own existential issues that may result in uncontrolled emotions, stress and sadness.

More recently, Lees *et al* (2014) found that the diagnostic label '*borderline*' was overused by some nurses when describing clients' suicidal behaviour. Furthermore, similar to many earlier national and international studies (Nehls 1999, Crowe & Bunclark 2000, O'Donovan & Gijbels 2006, James & Cowman 2007), the use of the label '*borderline*' also described as '*personality disorder*' was considered to have inherently negative connotations and was sometimes used as a rationale for not engaging with a client, in particular clients who self-harm. Sadly, there is much evidence in the nursing literature over the last two decades on the negative stereotyped attitudes about people who experience self-harm, from both nurses' and clients experiences (Thompson *et al* 2008, Mc Hale & Felton 2010). Consequently, clients often feel criticised, blamed, rejected or having their self-harm (distress) minimised by the use of pejorative terms and labels such as, '*cutters*', '*attention-seeking*', '*manipulative*' or '*personality disorder*' (Babiker & Arnold 1997, Inkle, 2010b). Against this background, the attitudes held by mental health nurses towards people who harm themselves, together with their knowledge, skill and sensitivity about self-harm are likely to influence their working relationship as well as the experiences and outcomes of those who self-harm. While clearly there is the need for further in-depth investigation of the nurse-client relationship, the findings worryingly indicate that many nurses do not have the best possible attitude to optimally meet the challenges and opportunities as well as being able to fully achieve therapeutic engagement with the suicidal person. Some studies posit that nurses' limited motivation and confidence to therapeutically engage with clients is attributed to a lack of self-awareness and reflective practice (Talseth *et al* 1997, Mc Laughlin 1999). In addition, several others studies identify the need for more adequate support and training to assist nurses for working positively with people in suicidal crisis (Meerwijk *et al* 2010, Talseth & Gilje 2011, Lees *et al* 2014).

Caring for the suicidal person: Clients' perspective

Although client involvement is considered crucial in improving and developing mental health services and practice (Ghio *et al* 2011); only a small number of studies draw upon clients' perspectives (Samuelsson *et al* 2000, Talseth *et al* 1999, Cutcliffe *et al* 2006, Gordon *et al* 2011), all support the importance of the nurse-client relationship. As described above, clients with suicidal behaviour are sensitive to the attitudes and responses of nurses and are in need of a therapeutic relationship that comprises genuine emotional engagement, including acceptance and tolerance of their feelings. In the UK, Cutcliffe *et al's* (2006) modified grounded theory study of twenty clients with experience of suicidal behaviour further supported the importance of the nurse-client relationship. They posit that the core aspect of mental health nursing care of the suicidal person comprises psychosocial processes and interventions to help move suicidal people from a death-orientated position to a life orientated position. This requires nurses to understand, guide, support and nurture the client, in particular their pre-suicidal strengths and beliefs. This in turn, helps the client to acquire a sense of trust and re-connect with a person that is, the nurse. Cutcliffe's study also identified that participants did not want to be treated mechanically by controlling interventions such as, special observations, which are discussed later in this chapter. Instead, clients preferred a close therapeutic relationship with the mental health nurse. Unlike earlier studies, they identified two significant findings, firstly, re-connecting with humanity was brought about by the person gaining understanding of and beginning to make sense of his/her suicidality. In addition, for this to take place nurses need to be present, albeit in different guises for longer periods of time than usually allocated to that allowed for '*crisis focussed*' models of care .

In Ireland, Gordon *et al's* (2011) study of suicidality among seventeen young men identified a number of key professional practices and processes that influence their suicide trajectories and life pathways. In this grounded theory study, young men reported that mental health professionals who made the most positive difference in their lives were those who worked with rather than worked on them. Consequently, this meant that the participants wanted professionals to be able to listen, tolerate and engage in interpersonal interactions and in particular at times of hopelessness, while

at the same time provide a supportive role throughout their unpredictable journeys of self-discovery. Similar to earlier studies, such practices demonstrated a belief in their potential to recover and consequently helped them to renew their hope in themselves. Similar to previous studies (Talseth 1999, Cutcliffe *et al* 2006), unhelpful practices identified included those that perpetuated their sense of difference and powerlessness such as, those that are controlling, confining, coercive and exclusionary. Some of these practices reflect the current care emphasis and interventions for this client group in mental health practice and will be discussed in terms of how they are implemented by nurses.

Caring for suicidal client: Nursing interventions

As well as engaging in a caring and trusting relationship, mental health nurses also need to undertake a comprehensive risk assessment with the potentially suicidal person. Currently, the concept of risk pervades and dominates the working lives of mental health nurses in many ways (Clancy & Happell 2014). Risk assessment and management is embedded in clinical practice and is required to take place for every client (Godin 2004). In mental health practice, risk can exist in multiple areas and can present for example, through violence, aggression self-harm, suicide, self-neglect and mental health relapse (Woods 2012). Assessment of risk in all these contexts is focussed around issues of short-medium and long-term risks. While this review focuses on suicide risk assessment and management by nurses, given the dearth of research in this specific area of risk evidence also draws from nurses' accounts of conducting risk assessment and management in a wider context.

Suicide risk: Assessment and management

Assessing and managing risk is a key activity of mental health nurses (Gerace *et al* 2013) and is of major importance in reducing the risk of a completed suicide (Royal College of Psychiatrists 2010). Furthermore as Gilbert *et al* (2011) point out, risk assessment is also crucial for developing risk management plans to prevent or minimise mental health clients' risks that will impede their recovery. Research literature and policy supports the inextricable link between suicide risk assessment and risk management (Kennedy 2001, Cucliff & Barker 2004, O'Connor *et al* 2011). Conducting a suicide risk assessment involves structured clinical judgement in the assessment of risk using actuarial measures to guide clinical judgement.

According to Doyle & Dolan (2002) structured clinical judgement bridges actuarial and clinical judgement by allowing the flexibility in practice to consider individual specific factors. Furthermore, this approach recognises that risks may change dynamically over time and the need for involvement of clients and carers in risk assessment and management. For many people, periods of feeling suicidal may be short-lived; while for others their suicidal thoughts might be always present, suicidal thoughts also can and do change over a very short period of time.

Actuarial risk assessment relies on fixed algorithms benchmarked by known outcomes of population groups and an estimate of absolute likelihood (Webb 2012). Therefore, actuarial prediction relies on ideas of chance and probability (Buchanan 1999). However, as Barbaree *et al* (2006) posits it is not necessarily based on any empirically supported theory of causation; instead it is only the correlation of known factors based on outcome. In mental health practice, this involves matching the individual set of risk factors for example young male, each of which has been shown to have a statistically positive correlation with increased suicide risk. Clinical judgement or prediction is based on reasoning about the individual. Undertaking a suicide risk assessment therefore requires mental health nurses to be familiar with the evidence-based risk factors, warning signs and protective factors for suicide, all of which need to be taken seriously. Notwithstanding their importance, mental health nurses also needs to be aware that just as each person has a different way of coping with stress; the person may also experience and behave differently when they are considering suicide. Therefore, appraising factors associated with a high risk of suicide also needs to be individually focussed. Risk assessment prediction methods have an important practical component since an assessment of a particular level of risk “will inevitably lead to some form of intervention to reduce, contain or otherwise ameliorate the risk thus changing the outcome” (Thomas *et al* 2009, p.3). As Cutcliffe & Stevenson (2007) argue, a thorough and accurate risk assessment that does not lead to intervention is not only inadequate but also leads to a pathway of frustration.

While conducting a comprehensive risk assessment is essential, prediction of suicide evokes much anxiety and concern and is fraught with difficulty and the level of accuracy (Briggs 2008). It is well known that there is little evidence for tools accurately predicting suicide or other risk behaviours such as harm to others, particularly in diverse client groups and contexts (Royal College of Psychiatrist

2010). Consequently, risk assessment remains an inexact science with results plagued by false-negative and false positive errors. Both these outcomes can have dramatic and long lasting effects on the suicidal person. However, as Cutcliffe & Barker (2004) posits, practitioners including mental health nurses continue to employ over-simplistic assessment tools in the hope that these provide accurate information to gauge suicide risk.

Interestingly, little reference is made in nursing research about the importance of therapeutic engagement and how it might impact on the process of undertaking a suicide risk assessment. When undertaking a suicide risk assessment, the person who is contemplating suicide or who has tried to take their life is likely to be feeling distressed at that time. Cutcliffe & Stevenson (2007) argue that the best caring response at that time is a non-judgemental approach and active listening. While listening to the suicidal person, the mental health may be able to draw the person into a supportive relationship and away from self-destructive thoughts at that moment. This intervention can also provide a safe period of time until other forms of help can be obtained. Consequently, undertaking a suicide risk assessment can be potentially life-saving, however, the assessment is dependent on what the person chooses to disclose or not to the mental health nurse. As discussed earlier in this review, it is therefore essential that the nurse is emotionally engaged while conducting the suicide risk assessment. Furthermore, determining the level of suicide risk is reliant on the person's disclosure of their suicidal thoughts; Cole-King (2010) points out that such disclosure must not be underestimated, which in itself can act as a protective factor.

Nurses' accounts of risk assessment and management

As stated earlier, research on how mental health nurses assess and manage risk mainly focuses on assessment and management of risk in a general context (Godin 2004, Gilbert *et al* 2011, Woods 2012, Clancy & Happell 2014). However, Godin's (2004) qualitative study reported that community psychiatric nurses (CPNs) primarily focused their concerns on clients whom they considered to be a potential risk to harm self or others. Evidence suggests that nurses invariably defined risk negatively mainly because it was framed as an intervention to prevent or deal with an adverse event (Godin 2004, Gilbert *et al* 2011, Woods 2012, Clancy & Happell 2014). In addition, risk was also closely associated with the potential of something going wrong and consequently ending up in the coroner's court together with

concerns about being blamed by the organisation for negative outcomes. Many participants felt that they were under pressure to think of risk in this way in their clinical practice although this was dependent on whether the organisational culture was either supportive and dynamic or oppressive and blaming (Clancy & Happell 2014). Not surprisingly, such understandings of risk assessment and management have the potential to lead to defensive clinical practice (Godin 2004, Alaszewski 2006). Godin (2004) reported that many participants were critical of society's and practice preoccupation with risk in mental health care and its impact on their clinical practice. They recognised that they had become increasingly preoccupied with risk-mitigating practices and often at the detriment of clients' needs (Godin 2004, Woods 2012).

Reliance on the use of clinical judgement as part of conducting a risk assessment was commonly reported by nurses. However, there were mixed responses about their use of a standardised risk assessment, some nurses considered risk assessment tools as too restrictive and unnecessary, whereas for others it was useful and informative (Godin 2004, Gerace *et al* 2013). Although risk assessments and management plans should be closely linked, Woods (2012) reported that risk assessment was not always considered as a whole event. This fragmentation was reflected in the gaps in the risk assessment and risk management process and how the risk information was used to formulate the risk management plans. Morgan (2007) stresses that risk assessment should not be seen as one off intervention. Regular re-assessment is essential and acknowledges the dynamic quality of risk assessment and is designed to help clients because it identifies changes in risks and subsequently the need for changes in interventions for the client. However, Woods (2012) reported that few changes were made when s reviewed and / or if new information was acquired. Contrary to most risk assessment policy and guidelines, Gilbert *et al* (2011) found variation in the sources of information used by nurses conducting a risk assessment and more worryingly, that the information they received from clients or carers was not always used to develop risk management plans. Further research is required to gain a greater understanding into this significant factor and to develop risk assessment and management practices. Clearly, there is a need to strengthening the link between risk assessment and management so that the interventions and care provided address the specific needs of individual clients and consequently help to facilitate their safety and recovery.

The practice of observing suicidal clients

Historically, the practice of observing clients has been viewed as central to the role of mental health nursing (Abel-Smith 1960). As a formal nursing intervention with policies and procedures, observation of clients has evolved over the years and continues to be one of the most common interventions in in-patient mental health care (Duffy 1995, Bowers & Parks 2001, Kettles & Addo 2009, Jones *et al* 2010). Observing clients is considered an important and integral part of mental health nurses' daily activities, which contribute to the multidisciplinary team's assessment of patients and their progress. Widely debated, special or enhanced observation is an intensified and often prolonged form of this intervention, which is commonly used specifically within acute mental health services (Cutcliffe & Barker 2002, Buchannan & Barker 2005). Despite its ubiquity, the nursing literature concerning special observation is mainly descriptive in nature and has received little research attention (Stewart *et al* 2010). The literature on observation generally falls into two groups; the substantial body of work on policies and practice and the limited research on the effects of observation on patients and nurses. Much of the work focuses on the most intensive type of observation that is, constant observation also referred to as special observation.

Special observations are usually imposed when a client is assessed as representing some degree of risk to themselves because of their behaviours or potential behaviours. Evidence from both quantitative and qualitative studies indicates that client safety was a predominant theme for placing a client under special or constant observation (Cleary *et al* 1999). Descriptive studies of client data from a random sample of 27 Trusts in England and Wales providing in-patient services found special observations were primarily used to reduce the risk of self-harm and suicide (Bowers *et al* 2000). A later study by Bowers *et al* (2003) of client-staff conflicts on acute-psychiatric wards found that clients categorised as 'self-harmers' were more likely to have received continuous special observations. Similar findings were reported by O'Donovan (2007) who conducted a small qualitative study of nurses' perspectives in an Irish mental health setting. Clients placed under constant observation also mentioned that the procedure was used to prevent self-harm (Ashaye *et al* 1997) and for their own protection (Cardell & Pitula 1999). Although there is a relationship between risk assessment and special observations, there are

few studies which attempt to relate the information gained in the assessment process to the level of observation prescribed for the client immediately after the initial assessment process. Kettles *et al* (2004) argue for further research and literature to support the decision making of all types of observations and in particular special observation and their subsequent practice. Furthermore, while the reasons for using special observation are likely to vary in different clinical settings, only one study examined this explicitly. Whitehead & Mason's (2006) study of forensic and non-forensic settings found that although nurses across both settings identified similar risk factors using a rank-ordering technique, statistically forensic nurses scored clients higher on factors associated with risk to harming themselves, and were therefore more likely to use special observations for these factors.

Understanding techniques of surveillance

Throughout the literature, definitions of special observations vary widely; common terms and phrases used include 'constant observations', 'close obs', 'one-to one', 'specials' (Bowers & Parks 2001, Jones & Jackson 2004). Special observations comprise a continuum of interventions, which involve assigning an identified person to the care of the at risk client for a certain period of time and above the minimum general level of observation required for all inpatients. The array of terms used over the years and the potential for inconsistencies and ambiguities in the terminology renders the use of special observation problematic at times and presents methodological challenges for the researcher (Stewart *et al* 2010). Policy documents dealing with special observations prescribe a varying number of levels of observations, whereby the nurse is specifically instructed to stay within a set proximity to the person being observed for example, at arm's length from or within sight of the patient, to observe the client within specified time intervals for example, every 15 minutes and to restrict the client's freedom of action (Jones & Jackson 2004). The distinction drawn between the levels of observations are known by various gradations for example, levels 1, 2, 3. Unlike routine observations, which are undertaken on an everyday level, special observations differ in terms of their intensity and the required closeness by which the person undertaking them should be to the person who is being observed. The frequency and nature of the observing contact usually reflects the seriousness of the assessed threat or risk to self (Holyoake 2013). However, little empirical evidence exists to guide nurses and medical staff as to which types of special observation work best and the few studies that are available

are inconclusive. Employing statistical analyses to examine the effects of special observations, Bowers *et al* (2008) found greater use of intermittent special observations was associated with fewer incidents of self-harm but there was no apparent benefit for constant special observations. Another study by Stewart *et al* (2009) found that hours of constant observation was not predictive of self-harm outcomes. However, the lack of statistical relationship between constant special observation and self-harm could reflect poor or inconsistent implementation of observation practices. Further studies of client level outcome and special observation are urgently required.

The panopticon gaze

In the last decade or more, *old* nursing techniques of surveillance or observation have been replaced by newer high-tech modes of surveillance, such as close-circuit television monitoring (Page 2006). Increasingly, more and more psychiatric settings or psychiatric units within general hospitals are utilizing audio-visual equipment to observe clients. Holmes (2001) suggests that the growing use of new monitoring technologies may be due to the need for improved therapeutic interventions or security measures, both of which concerns “the needs of the surveyed and the surveyor” (p.8). Mc Cahill & Norris (2002) posit that the use of CCTV can create a panoptic phenomenon. Panopticism or ‘panopticon’ is a central concept used by Foucault to theorize about surveillance and related disciplinary regime (Foucault 1977). Based on Jeremy Bentham’s work on prisons in 18th century Britain, Foucault referred to the panopticon as a combination of architectural design and visual effect that allows one guard to see every inmate from a specific point, while at the same time preventing the inmates from seeing who is watching. For Foucault (1995 p.173), “the perfect disciplinary apparatus would make it possible for a single gaze to see everything constantly”. The intention behind the gaze is to induce a state of permanent visibility, thereby creating an automatic functioning of disciplinary power (Foucault 1995). Monod (1997) asserts that individuals who are observed or believe that they are being observed therefore end up internalizing such surveillance. Within a nursing context, the use of technology enables the nurse in the nursing station to observe without ever having being seen by the patient who is observed. However, while observation may easily be achieved it is not without its disadvantages. As Page (2006 p.35) posits, making “the office the panoptic hub of a ward” encourages nursing staff to migrate to the office and are therefore less likely to move around the

ward, which not only isolates staff from clients but also reduces opportunities to engage with them.

Notwithstanding the plethora of terms used in clinical practice, the rationale for imposing special observations for in-patients who present some degree of risk to themselves is consistent throughout the literature that is, to prevent the person injuring him/herself and to ensure the welfare and safety of the client by maintaining a high level of vigilance (Stewart *et al* 2010). The Mental Health Commission (2007) recommend that special observations are carried out by an allocated registered nurse in all approved centres that is, a registered hospital or in-patient mental health facility. Similarly, Bowers *et al* (2000) survey of NHS Trusts in England and Wales reported that special observations were usually carried out by registered nursing staff; however, they also found that trust policies varied as to whether agency nurses or nursing assistants were permitted to carry out all levels of observations. Reynolds *et al* (2005) single site study found that special observations were carried out primarily by healthcare support workers without formal training in observations. In the US, similar findings were reported whereby registered nurses, mental health technicians and lay workers or personnel known as sitters were found to be responsible for special observations (Green & Grindel 1996, Pitula & Cardell 1996). Although dated, Duffy's (1995) early work on nurses' experiences of special observation reported that the low status of special observations as a nursing activity means that they are often delegated to unqualified staff; a practice that may still apply to today's practice in some mental health settings.

Implementing the therapeutic gaze

Decisions regarding the implementation of special observation should ideally be a collaborative multidisciplinary process; however, historically several studies reported that the authority to initiate special observations procedure was usually the sole prerogative of doctors (Aidroos 1986, Childs *et al* 1994, O'Donovan 2001, Reynolds *et al* 2005). Barker & Cutcliffe (1999) posit that following their initiation, nurses then perform a subservient role of ensuring the client's safety during the absence of the doctor. Although dated, Child's *et al* (1994) study reported that even when nurses were empowered with the authority to initiate a special observation policy; it was more often at the request of the medical staff. Notwithstanding the fact that the authority to initiate and terminate special observations lies primarily with the medical

staff; Duffy's (1995) study on nurses' experiences of special observations for suicidal psychiatric in-patients, reported that special observations were usually conducted at the suggestion of the nursing staff. Similarly, Bowers *et al* (2000) survey of NHS Trusts found that in 50% of cases, the initiation of special observations was stated to be carried out by joint medical and nursing decisions. Although nurses may not formally prescribe the order for observation levels, Bowers *et al* (2000) assert that they can and do have some influence prior to their implementation. Some early studies found that nurses did not always agree with the doctor's decision to place a patient under special observation (Cleary *et al* 1999, Dennis 1997) and once initiated the procedure was sometimes modified by nurses (Aidrros 1986) and on occasions with the agreement of the junior doctor (Duffy 1995).

In contrast to the initiation of special observation, greater consensus exists in the literature about who is responsible for their termination, which in most instances is carried out by a doctor (Stewart *et al* 2010). Bowers *et al* (2000) found only one study, which reported a joint medical and nursing decision on terminating special observation in the majority of cases. Notwithstanding this, the decision to formally reduce or terminate observation is often at the suggestion of nursing staff (Duffy 1995). However, the reliance on doctors to terminate special observations can have unforeseen consequences for both those being observed and their observers. Duffy (1995) found that since only ward doctors were responsible for terminating special observation, this rarely occurred at weekends due to the availability of only duty doctors. As a result, this meant that clients could be kept under observation for longer than necessary. Interestingly, few studies on special observation to reduce the risk of self-harm and suicide provided data on the duration of the special observation and where rates were reported there were wide variation in the methods employed to calculate them (Stewart *et al* 2010). Comparison of findings across studies is problematic due to the lack of standardised measures in the literature. Studies that did record the duration of special observations reported wide variance ranging from 34 hours (Pitula & Cardell 1996) to 211 hours (Jones *et al* 2000a). In most cases, special observations lasted for 2 days or more (Stewart *et al* 2010). However, some clients were under observation for very long periods, ranging from 3.5 days (Pitula & Cardell 1996) to 864 hours (Jones *et al* 2000a). In contrast, the minimum reported

shortest period ranged from 4 hours (Cardell & Pitula 1999) to 2 days (Vrale & Steen 2005).

Nurses' and clients' experiences of special observations

Throughout the literature, more evidence albeit limited, exists about nurses' than clients' views of special observation, most of which comprise small qualitative studies. Overall, nurses viewed special observation as a necessary intervention, especially for those at risk of self-harm and suicide; however, a consistent theme across studies identified special observation as stressful to conduct (Reid & Long 1993, Duffy 1995, Neilson 2001, Rooney 2009). In particular, many studies reported nurses' discomfort with the intrusiveness of the intervention and the potential for patients to react aggressively to it (Stewart *et al* 2010). Special observations can vary in their degree of intrusiveness and restrictiveness and are therefore likely to arouse strong emotions in the client and staff. Moore *et al* (1995) posit that nurses can be subjected to hostility, abuse and acting out behaviour by the clients they are observing. For nurses conducting special observations, achieving a balance between providing the required level of observation to maintain safety and at the same time trying to minimize stress to the client is challenging. Some studies emphasised the need for therapeutic interpersonal communication with clients under special observation and recommended nurses to view it as an opportunity to develop a therapeutic alliance rather than a ritualistic task to perform (Long & Reid 1996, Fletcher 1999, Whittington & McLaughlin 2000, Vrale and Steen 2005). Notwithstanding, nurses tend to perceive the practice of special observations as custodial rather than therapeutic (Reid & Long 1993, Westhead *et al* 2003). Duffy's (1995) study reported that nurses received 'no official training' or clinical supervision for special observation. Since then, Barker & Cutcliffe (1999) argue that this theme has been reported repeatedly in the literature and without any detailed recommendations about how to prepare nurses to undertake special observations beyond the basic aspects of risk management and physical containment. In some studies, qualified and unqualified staff both stated that they had insufficient preparation or were given any guidance about what to do or say when undertaking constant observation (Neilson & Brennan 2001, Rooney 2009). Viewed as fundamentally a practical task, nurses frequently cited clinical experience as the source whereby they learnt the necessary skills from their mentors and more senior nurses to undertake special observations (Rooney 2009).

From clients' perspectives, while the presence of someone during special observation engendered feelings of safety (Lehane 1996); most studies, albeit of small scale, reported resentment because of the associated intrusion and restrictions that it involved (Pitulla & Cardell 1996; Jones *et al* 2000b). However, clients' experience of special observation was strongly influenced by nurses' attitudes and behaviours, which highlighted the importance and at times the absence of, supportive interactions from staff (Pitula & Cardell 1996, McLaughlin 1999). In Cardell & Pitula's (1999) study, suicidal inpatients' reported that positive attitudes from observers engendered hope and self-confidence and ultimately greater compliance with the team, whereas if staff showed a lack of empathy or recognition, they experienced feelings of distress and anxiety. Clients and in particular suicidal patients, stated they wanted to be observed by nurses they knew and could talk to (Jones *et al* 2000b); lack of familiarity prompted negative attitudes towards agency staff who observed them (Dodds & Bowles 2001).

The intervention of hope

Another intervention reported to be used by mental health nurses when working clients with suicidal behaviour is hope. As a concept, hope is not new. Historically, hope has been situated as an important topic in the domains of mythology, literature, art, philosophy and religion for centuries. It was not until the late 1950s however, that hope found its way into psychiatry when Menninger (1959) identified it as essential to the profession of psychiatry and important in initiating therapeutic change, willingness to learn and a sense personal well-being (Grewal & Porter 2007, Schrank *et al* 2012). Since then, much research has been conducted investigating hope in various fields of medicine and different settings for example Lalor *et al* (2009), Rhodes *et al* (2009), with oncology being the most notable (Olson 2011). Nursing scholars in general, have tried to understand hope as a construct that can be operationalized, measured, assessed and manipulated by others (Wang 2000). In mental health nursing, the increasing, albeit limited, recognition of the importance of hope within clinical practice and research is a more recent phenomenon (Herth 2000). Contemporary mental health nursing literature recognizes the therapeutic potential of hope and its position of relative importance. Cutcliffe & Koehn's (2007) systematic review of the literature that focusses on hope and interpersonal mental health nursing reported that much of this nursing literature is mainly descriptive and

focusses on the substantive areas of personal recovery, schizophrenia, older adult, depression and suicide (Cutcliffe & Koehn 2007). In relation to suicide, they reported that despite the well documented relationship between hopelessness and suicide and mental health nurses' role in working with suicidal people, the literature was notably limited and there was a distinct lack of research. The literature that did exist indicated that mental health nurses appear to play a critical role in fostering hope and helping to ameliorate hopeless and suicidal feelings. Findings within this literature also showed that in inspiring hope in this client group, the formation of a caring interpersonal relationship is essential from the outset. Studies of hope as an intervention with clients who are suicidal are limited and while nurses espouse the potential therapeutic value of hope, gaps remain in the substantive knowledge base; as Cutcliffe (2009) concludes "our understanding of hope, hoping and hopelessness are at a relative early stage" (p.845).

Definitions of hope abound in the literature along with models and instruments for its measurement (Larsen *et al* 2005). Described as complex, multidimensional and dynamic, with a potentially powerful factor in healing (Herth 2000); hope is viewed as a universal concept, yet it may mean different things in different cultures and among different groups (Schrank *et al* 2012). Although no universal definition of hope exists and the way in which it is conceptualised varies; there are many common elements in the understandings of hope such as; its future oriented (Holt 2000), motivating (Stotland 1969), pervasive (Cutcliffe 1997), involves expectancy (McGee 1984) and above all, many leading hope researchers believe hope is an essential element necessary to engagement in life; without hope life loses purpose (Vaillot 1970, Miller 1989, Herth 2000, Larsen *et al* 2005). Notwithstanding the various attempts to define hope, Cutcliffe & Herth (2002) argue that there is not one definition of hope in the theoretical and empirical literature that encapsulates all that hope is and more specifically how it relates to health, disease and health care.

Theories of hope

There are various conceptual models for hope; most of which are derived from varying qualitative methodologies and differing populations. While different conceptualisations of hope vary, support for the importance of hope in nursing is consistent (Cutcliffe 2009). Dufault and Martocchio's (1985) seminal study of hope deduced from observations and interviews with elderly cancer patients over a two-

year period led the study of hope in healthcare and continues to be quoted frequently in the nursing literature. Subsequently validated on various populations, Dufault and Martocchio (1985) developed a multidimensional model that differentiated between two spheres of hope general and specific, together with six dimensions of hope: affective; cognitive; behavioural; affiliative; temporal; and contextual. Fundamental to Dufault and Martocchio's model is that hope is not regarded as absolute but may be present to varying degrees within the six dimensions, which together "provide a gestalt of hope" (p.381). Dufault and Martocchio (1985) concluded that hope and hopelessness are not at the opposite end of one continuum or that hopelessness is the absence of hope. Instead, they posited that some sphere or dimension of hope is always present (p.389). Another model often referred to in the literature is that offered by Snyder and colleagues (1996) who offer a more narrow goal-focused perspective of hope. Viewing hope from a cognitive-behavioural perspective, Snyder's hope theory conceptualizes hope as the interplay between three component parts: cognitive processes, motivation and desired goal (Snyder 2002). Snyder and colleagues also developed hope scales focussed on the attainment of goals and examined the relationship between hope and various life outcomes. Another scale based on Dufault and Martocchio's taxonomy is the Herth Hope Index (HHI) (Snyder *et al* 1991), which comprises twelve items on a 4-point Likert scale.

Inspiring hope and the suicidal client

In mental health practice, nurses frequently encounter situations in which their clients are suffering from a 'lack of hope'. Lack of hope or hopelessness has been put forward as a significant risk factor not only of mental disorders in general but specifically in depression and suicidal behaviours (Beck 1963, 1974, 1986, Hanna 1991). While individuals can maintain their own level of hope to a certain extent, at times of crisis and distress this may not be always possible. Suicidal people clearly need hope; Cutcliffe & Barker (2002) believe that "mental health nurses are ideally placed to be one such source of hope" (p.617). They argue that hope is inspired in the context of supportive relationships (Barker & Cutcliffe 2000, Cutcliffe & Barker 2002, Edey & Jevne 2003, Cutcliffe 2004, 2009) that is, the presence of another human being who demonstrates unconditional acceptance, tolerance and understanding. Hope is interwoven with caring practices and providing help (Benner 1984, Cutcliffe 1995, Cutcliffe & Herth 1996); engaging in the practice of helping /caring also places mental health nurses in key positions to have conversations with

their clients about hope and strategies both short and long term, to find renewed hope in any situation. In practice, however there is a general consensus that similar to the action of helping, the processes of hope inspiration needs to be subtle, unobtrusive and implicit rather than explicit (Herth 1990, Miller 1989, 2007, Cutcliffe & Grant 2001); as Frankl (1959) posited one cannot be forced to become more hopeful, hope cannot be ordered or commanded. Similarly, as Cutcliffe & Barker (2002) point out, suicidal clients cannot be “forced to become more hopeful; forced to feel less suicidal” (p.617).

Notwithstanding the therapeutic potential of hope in mental health nursing practice, there is no specific theory or research that informs nurses of how to inspire hope in suicidal clients (Cutcliffe & Barker 2002). Talseth *et al's* (1999) small study of in-patient suicidal men and women's experiences of being cared for by mental health nurses reported that ‘communicating hope to the patient’ was a subtheme of a caring relationship whereas ‘communicating hopelessness’ was characterised by the lack of a confirming relationship. In addition, participants also reported that nurses’ ability to foster hope was dependent on having the time to speak with and listen to their patients. Talseth *et al's* (2001b) later study of family members’ of patients at risk of suicide, similarly identified that being met by mental health care workers who were willing to enter into a trusting, consoling and respectful relationship helped them to encounter the experience of “entering into hope” (p.255). Other literature has focussed on highlighting the need to change traditional mental health nursing practices such as close, non-routine observational approach and instead to incorporate active engagement and hope inspiration when caring for suicidal clients. Cutcliffe (2004) posits that hope appears to be rekindled by making a meaningful connection, conveying acceptance, actively listening to the client while endeavouring to understanding the nature of the person's problems and needs. The focus of the nurse's engagement with the client therefore is to understand the client's hopelessness and to discover means to maintain and engender his/her capacity to hope. Notwithstanding the therapeutic potential of these interventions, there remains the continuing need for well-defined interventions studies to test the efficacy of such interventions designed to strengthen hope.

No-suicide contracts

The use of no-suicide contracts (NSC) also referred to as ‘no-harm contracts’ within the care of the suicidal person has gained increasing interest in some countries, for example the United States (Stuart 2005). A no-suicide contract is an agreement between the client and the clinician or mental health nurse wherein the potentially suicidal client agrees not to harm him/herself for an agreed period of time (Popenhagen & Qualley 1998). Contracts can be verbal written or both, but are not legal documents. Historically, the contract for safety or no-suicide contract dates back to a paper by Dyre *et al* (1973); she studied the use of no-suicide contract in the context of an outpatient therapy practice. Originally, the practice of no-suicide contract was intended to assist in evaluating and planning, as well as to provide a way to share the burden of assessment and responsibility with the client. Some years later, Twinane (1981) introduced the concept of NSC to nursing. However, since then there is a dearth of theoretical and/or empirical nursing literature that supports the utility of NSC; the limited literature available is primarily discursive, and anecdotal. Consequently, little is known about the extent of their use by mental health nurses and more importantly how they are being implemented. Research undertaken albeit sparse was conducted in New Zealand (Farrow *et al* 2002, Farrow 2000) and the United States (Drew 2001). Farrow *et al's* (2002) qualitative study of the NSC from nurses’ and clients’ perspectives reported mixed opinions about their effectiveness. Drew’s (2001) retrospective review of medical records reported that the prevention of self-harm behaviours by the use of no suicide contracting was not shown. She also stressed the need for a thorough ongoing assessment of suicidal risk whether or not a patient has agreed to a no-suicide contract. Clearly, there is a need for more investigation to explain and evaluate whether NSC can be both a necessity and a liability in caring for the suicidal person. Notwithstanding this, it important to note that NSC should never be used as a substitute for a thorough suicide risk assessment, and initiating no-harm contracts offer no guarantees that the person will not make an attempt or indeed die by suicide.

Nurses’ responses to the death of a client by suicide

Suicide is a relatively rare event, yet for mental health nurses the possibility of caring for a client who dies by suicide is high over the course of their career (Kleespies & Dettmer 2000, Collins 2003, Bowers *et al* 2006). The death of a client through

suicide is a tragedy that mental health nurses strive hard to prevent. For those left behind, relatives, friends and staff the impact can be traumatic and as Bowers *et al* (2006) points out for mental health nurses it can include longstanding impact on their practice. Mental health nurses may experience the death of a client by suicide at various stages of the client's care; some clients may die while in hospital, or when discharged from in-patient care and living in the community (Qin & Nordencroft 2005). Research and anecdotal evidence suggests that each situation presents a unique and potentially emotionally devastating experience for the nurse(s) that knew and/or cared for the client. However, similar to the limited research on mental health professionals' experience of client suicide in general (Christianson & Everall 2009) little is known about how mental health nurses experience such an event and as such it remains an under-explored area. Both nationally and internationally, there is a dearth of published research undertaken by or referring specifically to mental health nurses' experiences of caring for clients who have died by suicide. One explanation put forward for the paucity of studies is that researchers have not included agencies with low base rates of client suicide, such as nurses (Valente & Saunders 2002). However, another significant contributing factor for the paucity of research is likely to be that of the sensitivity of client suicide and the sense of professional and personal discomfort and distress that it may evoke for both potential participants and researchers. In the limited studies that do exist, most published research on nurses' responses to client suicide comprises small descriptive qualitative studies and are primarily confined to the experiences of nurses working in in-patient units. Research on mental health nurses' responses to client suicide will be presented as follows; impact of client suicide on nurses, factors that impact on nurses' responses and how nurses cope in the aftermath of client suicide.

Impact of client suicide on nurses

While mental health nurses' responses to the death of a client by suicide may parallel those of their psychiatric colleagues (Midence *et al* 1996, Wallace 2008), their responses may differ depending on the nature of the relationship with the client and knowledge of the suicide. Research has identified that death of a client by suicide can evoke a range emotions in nurses such as; distress and anger (Valente & Saunders 2002) guilt (Midence *et al* 1996), fear, panic, sadness and grief (Talseth *et al* 1997). Similar feelings were found in two small descriptive studies conducted in Ireland on mental health nurses' experiences of client suicide (Donnelly 2012) and client

suicide and attempted suicide in in-patient setting (Bohan & Doyle 2008). However, with reference to the latter study, while attempted suicide can undoubtedly be a frightening and distressing experience for both the client and mental health nurse(s); it is likely to evoke a completely different response to that of a completed suicide and as such is not comparable.

As well as the possibility of sustaining an acute sense of loss; Cleary *et al* (1999) assert that a client's suicide may also represent a sense of professional failure or helplessness (Bohan & Doyle 2008), which can have a significant impact on nurses both personally and professionally. Bowers *et al's* (2006) survey of 56 multidisciplinary team members, 17 of whom represented mental health nurses working in an in-patient setting reported that a client suicide prompted a number of fears; fear of blame, fear of threat to registration and fear of a repeat incident. Bowers *et al* (2006) also acknowledge that participants may have censored some responses such as, anger for fear that it might be construed as insensitive or socially inappropriate following a client suicide. A recent Irish study by Gaffney *et al* (2009) surveyed multidisciplinary frontline staff with an average of 12-18 years' experience in relation to suicide (n= 447) experiences and needs across community and inpatient services. Among the participants, nursing was the most represented staff type in the study 45.7% (n=204) who reported concerns about other clients and the community at large (27.8%). Although rarely addressed in the literature, nurses also identified personal experience of suicide outside the workplace as something that would influence their reactions and emotions and as a result was likely to impact on their ability to conduct their clinical responsibilities (33.3%). Some nurses (30%) also reported feelings of professional self-doubting together with apportioning self-blame and feeling that they have failed the person and their families. Robertson *et al's* (2010) small study on mental health nurses' experience of a client suicide found that this process of professional self-doubting involved questioning their own interventions and practice, ruminating on events prior to the suicide in an attempt to identify actions that they could have taken to prevent the suicide from occurring. These responses as well as preoccupation with the client suicide are similar to those reported by other mental health professionals (Hendin *et al* 2000, Ting *et al* 2006, Villeux 2011). While mental health nurses' responses to client suicide may be similar to their multidisciplinary colleagues, each client suicide is unique and also the way in

which it impacts on the mental health nurse involved. Consequently, no two mental health nurses will respond in the exact same way to a client suicide.

Factors that impact on nurses' response to client suicide

There is overall consensus that one of the key factors that impacts on nurses' response to a client's suicide is the type of relationship they had with the client (Valente & Saunders 2002, Bohan & Doyle 2008, Gaffney *et al* 2009). The nature of the relationship with the client, how well the client was known by the nurse and the extent of their involvement in their care were identified as key factors affecting their responses to the suicide. These findings echo studies of other mental health professionals' responses to client suicide who conclude that the impact of a client suicide is mediated by the relationship with the client and the support they received (Hendon 2000, Campbell & Fahy 2002, Villeux 2011). Studies of trainee psychiatrists also identified other contextual issues that can contribute to the levels of distress such as, method, timing and location as well as characteristics of clients such as age and diagnosis (Dewar *et al* 2000, Ballard *et al* 2008).

As with all therapeutic relationships, each nurse client relationship is unique; nurses' responses to client suicide are therefore contextual and as might be expected individual differences are likely to influence how each nurse responds to a client's suicide. However, Spencer (2007) points out that unlike other health professionals who might be exposed to the deaths of clients in the course of their work; mental health staff and mental health nurses in particular, are expected to develop a sustained relationship with clients in a direct attempt to reduce the risk of taking their own life. She concluded from her small qualitative study, which comprised predominantly mental health nurses that this additional expectation can increase the sense of responsibility or failure if the therapeutic relationship ends because of the client's death. Interestingly, this important dynamic has received little acknowledgement or recognition in the nursing literature or research on caring for the suicidal person and clearly warrants further examination.

Similar to other studies involving mental health professionals (Hendon 2000, Foley & Kelly 2007); mental health nurses also identified the reaction of the family as a significant factor upon levels of stress after a client had died by suicide. In particular, this concerned how the family would view their professional role in the suicide, the

degree to which they would be blamed by the family and how the family should be responded to outside of work, for example attending the funeral or living within their neighbourhood (Gaffney *et al* 2009). Although not explored, it may well be that similar to the therapeutic relationship concern about families' reaction is also contextual and dependent on how well known the family is to the nurse. This may be of particular significance for community mental health nurses whose work involves working closely with clients and their families. However, this area needs further examination especially since most published studies on nurses' responses to client suicide are biased towards in-patient settings.

Coping with client suicide

Midence *et al* (1996) posit that coping with a client's suicide may be one of the most difficult tasks for nurses. Some nurses reported feeling isolated and fearing criticism from colleagues following a client suicide as well as noticed being hyper-vigilant in their work practices (Valente & Saunders 2002). Gaffney *et al* (2009) reported that mental health professionals' gender can influence their experience of a suicide. While physical and psychological symptoms associated with the experience of the client, such as lack of sleep, irritability were reported equally by men and women; females across different mental health professions reported to be more adversely affected than males, particularly in relation to self-doubt, feelings of responsibility and feeling of blame. Akechi *et al's* (2003) earlier case study of a psychiatric nurse also reported that client suicide can contribute to psychological and post traumatic symptoms. A more recent Japanese study by Taakashasi *et al* (2011) using the Impact of Event Scale (IES) a well-tested and validated instrument to determine post traumatic symptoms in mental health nurses (531) following a client suicide reported that 13.7% scored high for posttraumatic stress disorder (PTSD). While this figure shows a significant level of stress among mental health nurses, similar studies need to be conducted to determine whether the findings can be applied to an Irish context.

While the need for organisations and service providers to provide effective support arrangements for all frontline staff following a traumatic event such as suicide has gained increasing recognition, there is a paucity of research into the resources and supports needed by staff (Spencer 2007). Nonetheless, similar to other mental health professionals for example, Foley & Kelly (2007), support is reported consistently by nurses as the most significant need in the aftermath of a client suicide (Spencer

2007, Bohan & Doyle 2008, Gaffney *et al* 2009). Support received, consisted primarily of peer support, yet both Donnelly (2012) and Bohan & Doyle (2008) reported that nurses struggled with a sense of helplessness when trying to comfort colleagues following a client suicide in an in-patient setting. Other types of support identified albeit to a lesser degree included debriefing, supervisors and line management. However, there is also evidence that where support is provided by supervisors, managers and particularly senior staff, it is experienced as very helpful (Linke *et al* 2002).

Spencer (2007) reported that mental health nurses preferred informal individual support as opposed to formal group debriefing. Further research is therefore required to provide a more comprehensive account of how debriefing is conducted and perceived by mental health nurses post client suicide. However, an inherent difficulty in examining resources and supports needed by staff is the subjective nature of support and consequently any planned intervention offered to an individual professional in the aftermath of suicide may or may not be interpreted as supportive. Similar to other studies, nurses also reported a number of needs in respect of training and education in relation to suicide, in particular, how to deal with the family, other clients and colleagues. Clearer guidelines, policies and specific protocols as well as information regarding their role and responsibility in the situation were also requested by nurses (Bohan & Doyle 2008, Gaffney *et al* 2009).

Summary and conclusion

This chapter explored the literature and limited empirical research on suicidality in the context of mental health nursing and people experiencing suicidal behaviours. Mental health nurses have a long standing history of caring for people who are suicidal. Working within the biomedical discourse, suicide or suicidal behaviour is viewed as a symptom of mental illness. In this context of mental health services, there is heavy reliance on particular ways of understanding the relationship between mental illness and suicidality and wherein much emphasis is placed on prevention and confinement in relation to suicidal behaviour. Although nurses play an important role in helping to prevent suicide as well as recover from suicidal crisis in a range of mental health settings; evidence suggests that nurses often struggle when

confronted with client suicidality and the inherent challenges they face in caring for the suicidal person.

Studies carried out in Europe and other countries including Ireland, albeit mainly descriptive qualitative studies focus predominantly on nurses' accounts of caring for suicidal clients primarily in in-patient settings. In addition, few studies integrate all the different aspects of mental health nurses' responses in relation to clients with suicidal behaviour. Research suggested that nurses' ability to engage and communicate with people who are suicidal is essential to maintaining and promoting the person's safety and well-being. However, evidence suggests that both nurses and clients feel dissatisfied with the quality of care provided albeit for different reasons. It is noted that as well as engaging in a caring and trusting relationship with the suicidal person, limited research exists on how nurses conduct suicide risk assessment and safety planning with clients. The reliance on conducting observation as an intervention to prevent client suicide is well documented, as well as the challenges and distress it caused for both nurses implementing it and clients being observed. Notwithstanding this, nurses endeavour to balance the right to control suicidal clients' destiny in order to save life and the fears and uncertainties that it engenders for them. Despite nurses' effort to prevent client suicide; few studies provide guidance about how they might respond if confronted with the death of a client by suicide.

In spite of the large amount of rhetoric on the importance of assisting people who present with suicidal behaviour as a dimension of suicide prevention within the health care literature, and more specifically nursing literature, little research is available about how mental health nurses undertake this role and in the absence of an overarching theoretical framework. Research available comprised small local qualitative studies suggesting that nurses' interventions are predominantly reductionist, fragmented and practised in a culture of protectionism. In addition, the research available does not provide a conceptual framework for understanding the processes nurses used to organise their interactions and work with suicidal clients. It was therefore considered more fitting to explore this topic from an 'emic' perspective, using a Grounded Theory methodology. Therefore the overall aim of this research was to develop a substantive theory of how psychiatric nurses respond to issues of suicidality in clinical practice context.

The next chapter will explore the philosophical and methodological underpinnings that guided this study.

Chapter Four: Philosophical and Methodological Underpinnings

Introduction

Researchers must be explicit from the outset about how they locate and position the research that they undertake (Mills *et al* 2006). For those conducting research, this means being able to identify the epistemological, ontological, theoretical and methodological assumptions that have shaped and guided the research process (Crotty 1998). This chapter begins with an exploration of the philosophical underpinnings of social constructionism. This is followed by a discussion of the Glaserian approach to Grounded Theory, which informed this study. Within the discussion, reference is made to the origins and background of grounded theory and how Glaser's approach differs from other modes of grounded theory such as, those by Strauss and Corbin and Charmaz. In addition, an overview of Glaser's classic grounded theory is provided coupled with the key methodological differences between classic and other forms of grounded theory. This is followed by a discussion of reflexivity and grounded theory. The chapter concludes with a statement on the philosophical assumptions that have guided the development of this Grounded Theory study.

Philosophical underpinning of research paradigm: Constructionism

Constructionism is a very broad and diverse perspective, which has evolved in opposition to objectivism and in some areas it has replaced the dominant approach to understanding knowledge (Crotty 1998). As an alternative to positivist and post positivist thought, constructionism has emerged as researchers tried to explore the subject of human emotions and experience (Schwandt 2003). Constructionism as an epistemology, means that human knowledge or meaning is not found or discovered; it is constructed (Crotty 1998). Burr (2003) suggests that with constructionism there is neither an objective or absolute reality nor truth; instead meaningful reality is constructed through our impressions and interpretations of phenomena that are culturally and historically defined. This means that we invent concepts, models and schemas to make sense of experience. From this understanding of knowledge, different people may construct meaning in different ways even if the phenomenon remains the same (Crotty 1998). Therefore, multiple realities exist as interpreted by

multiple viewpoints, which are continually refined, affirmed or disproved over time in response to new experiences (Berger & Luckman 1966) In addition, given that we construct our interpretation against a backdrop of shared understandings and practices such as language (Schwandt 2003); these realities also comprise an inevitable historical and sociocultural dimension to this construction. Truth or meanings are therefore according to Crotty (1998) constructed by human beings as they engage with the world that they are interpreting and consequently are subject to change in social experiences. There are many varieties of constructionism that have evolved and diversified over time. Constructionism can be classified broadly into two major perspectives that is cognitive constructionism (Heap 1995) or constructivism (Crotty 1998) and social constructionism (Gergen 2001). These terms are frequently used in different contexts as though there was a shared agreed meaning of the terminology used, however, many different versions exist and have different meanings to different disciplines (Gergen 2001, McLeod 2011). It is therefore important to distinguish between constructivism and social constructionism.

From a cognitive constructionist (constructivist) perspective, meaning is not passively received or discovered through the senses; instead each individual mentally constructs the world of experience through cognitive processes as they engage with the world in a dynamic manner (Young & Colin 2004). Cognitive constructionism is therefore distinguished by its focus on the individual and how the person cognitively engages in the construction of knowledge (Schwandt 2003). As Crotty (1998) points out, developing meaningful reality only emerges when consciousness engages with the world. Social constructionism, arising from the seminal work of Berger & Luckmann (1966) became influential within the social sciences during the latter half of the twentieth century. Although not in disagreement with cognitive constructionism, social constructionism has a social rather than an individual focus and is therefore less interested in the cognitive processes that accompany knowledge (Harré 1986, Young & Colin 2004). As Heap (1995) clarifies social constructionism is concerned with collective construction whereas cognitive constructionism (constructivism) emphasises meaning that is cognitively constructed by the individual. Constructionism therefore assumes that people are born into cultures that have already constructed meaning about their objects and symbols, and are then imparted as people interact (Crotty 1998). Notwithstanding this, constructivism and

social constructionism are not diametrically opposed; in fact both are inter-related and therefore each cannot function in isolation. Constructivism is a consequence of social constructionism (Heap 1995), however, as Harré (1986) points out it is not just our thoughts that are constructed for us, our emotions are also socially constructed. Constructionism embraces the whole gamut of meaningful reality, for example our beliefs, attitudes, responses, feelings towards suicide and self-harming behaviour are socially constructed; there is no exception. The individual's understanding of meaning is therefore shaped by sociocultural influences that manipulate their behaviours, experiences and thinking (Crotty 1998).

Social constructionism comprises a number of key assumptions, which are underpinned by the view that knowledge is always constructed through the lens of our own interpretation and understanding. This in turn is shaped and informed by the various cultural and institution discourses we have been exposed to and internalized. Social constructionism therefore considers culture as the source that directs and organises our behaviour and experiences rather than the result of human thought and behaviour. Notwithstanding this, any knowledge produced which is taken for granted (Burr 2003) is critically challenged since knowledge or knowledge production that is; research is open to constant change and revision (Schwandt 2003).

Another important assumption of social constructionism lies in the domain of language. Language is one of the most significant forces that shape our experiences and helps to explain our ideas and feelings to others; we use it to explain things to ourselves. In addition to language, meaning is also expressed and communicated through other means such as artefacts, rituals or practices (McLeod 2011). A central tenet of social constructionism is that reality is a function of the collective generation of knowledge through socialisation; therefore knowledge is readily available, sustained and reconstructed when we are engaging and interacting with each other (Berger & Luckmann 1966). Knowledge or meaning is therefore not a static concept; what we know and how we understand is fluid and context dependent at a given time. As Burr (2003) points out the knowledge of the world is constructed between people therefore social action and knowledge goes together. From a social constructionist stance however, Hyde *et al* (2004) argue that the importance lies in understanding how this knowledge has pervaded the public consciousness and as such, becomes knowledge that is taken for granted as opposed to the knowledge that

describes a particular phenomenon. Consequently, the emergent analytic procedures of grounded theory were especially applicable to the process of learning about suicide, which is embedded in social situations and influenced by individuals as well as organisational structures.

Grounded Theory: Background and origins

According to Suddaby (2006, p.633) “like most difficult subjects, grounded theory is best understood historically”. That is the background and origins from which it emerged. Grounded theory was developed in the mid-1960s by two sociologists Barney Glaser & Anselm Strauss during their research on the experience of dying patients in hospitals in the United States. Through their work they developed a research method and published in *The Discovery of Grounded Theory* (Glaser & Strauss 1967), which explained the methodology they had been using. Their seminal text outlined a set of principles and procedures designed to assist the researcher to generate a substantive theory grounded in empirical data. With its origins in sociology, grounded theory placed much importance on developing an understanding of human behaviour through a process of discovery and induction. At the time, grounded theory challenged the then traditional and dominant quantitative research process of hypothesis testing and deduction and represented an alternative to other more established research approaches (Thomas & James 2006). Its development also raised the status of qualitative research in the social sciences by giving it a more solid base (Dey 1999). Nearly fifty years later, its reputation as an accessible, credible and well explained method in qualitative inquiry has grown. Grounded theory has achieved extensive popularity as a method of social analysis and has been used widely by a range of disciplines not only in nursing but in other areas of social science including education and psychology (Charmaz 2006, Thomas & James 2006, McLeod 2011). According to Holloway & Wheeler (2002) one of the attractions of using grounded theory in nursing is that it offers a set of clear specified procedures to collect and analyse data. However, while the series of procedural steps may appear formulaic, as a methodology grounded theory is in fact flexible enough to allow the researcher to follow leads and use a variety of data and collection methods and can be adapted to different circumstances.

Originally, the grounded theory method (Glaser & Strauss 1967) was shaped and informed by two schools of thought, the Chicago school of pragmatism and the Columbia school of quantitative research. Glaser and Strauss each contributed a unique set of assumptions to the development of grounded theory as a method; Glaser brought positivistic beliefs of objectivity based upon his rigorous quantitative training at Columbia University with Paul Lazarfield, whereas Strauss took a pragmatism stance influenced by his training in symbolic interaction with Herbert Blumer. The epistemological assumptions, logic and systematic approach of grounded theory combined both the depth and richness of qualitative interpretative traditions with the logic, rigor and systematic analysis inherent in quantitative research (Glaser & Strauss 1967, Dey 1999). Since its development grounded theory has been altered and modified in many ways, the most notable change occurring as a result of the split between its original co-founders.

One of the main and well documented controversies surrounding grounded theory concerns the methodological split between the co-origins Glaser and Strauss. This schism occurred after Strauss published *Basics of Qualitative Research: Grounded Theory Procedures and Techniques* with Juliet Corbin (Strauss & Corbin 1990). Glaser (1992, p. 2) described their book as follows; ‘It distorts and misconceives grounded theory, while engaging in a gross neglect of 90% of its important ideas’. This was followed by his book ‘*Basics of Grounded Theory: Emergence vs. Forcing*’, which highlighted the differences in what he believed, was the original grounded theory from Strauss and Corbin’s work. Within the literature there have been a number of discussions focusing on the differences and similarities between Glaser’s (1978, 1992) and Strauss’ (1987, 1990) version of grounded theory, including Glaser himself (Glaser 1992, Glaser 2003). Glaser (1992) argues that his approach is interpretative, contextual and emergent whereas Strauss and Corbin’s version is more likely to lead to the forcing of perceived notions of the data. For Glaser (1992), what Strauss had written was not grounded theory but a move away from the original form and a remodelled method which he called a “full conceptual description” (p.123). After some time the two co-founders went their separate ways and each began producing literature on their own methods and the specifics of how a ‘grounded theory’ was to be generated (Glaser 1978, 1992, Strauss 1987, 1990). As Stern (1994) concludes, what began jointly, eventually split into separate and different modes of grounded theory - the Straussian and the Glaserian.

Grounded Theory as a methodology: Glaser's approach

Glaser's approach, also known as the traditional or classic grounded theory, is recognized as having retained both the "spirit and substance of the original work" (Mills *et al* 2007, Locke 2001, p.64), and rigorously follows the principles that were articulated in 1967. His publications over the years together with 'Discovery' provide detailed accounts of the essential elements that comprise what has come to be known as classic grounded theory methodology (Glaser 1978, 1992, 2001, 2003). Classic grounded theory is a distinct, well-established, credible and rigorous methodology that offers a set of directions and a means of generating theory while also allowing for creativity and intuition (Glaser 1998, Glaser 2001). At the core of Glaser's approach (Glaser & Strauss 1967, Glaser 1978) is the "...emergence, discovery and inductive theory generation" (Glaser 1992, p. 122).

One of the interesting paradoxes of grounded theory since its inception is that it is predominantly an inductive methodology, yet there is also some deduction in grounded theory (Glaser & Strauss 1967, Glaser 1998, Christiansen 2008). According to Goulding (2005), induction in grounded theory refers to the development of theory that emerges out of or that are grounded in data, as opposed to commencing the study with preconceived ideas. This means the researcher does not begin with a hypothesis about the phenomenon to be studied but instead remains open to whatever theory emerges from the data (Glaser & Strauss 1967). During the development of inductive theory the researcher moves from description of the data to more abstract generalisations and the development of theory (Reichertz 2007). Researchers in grounded theory also use carefully grounded deduction for example theoretical sampling (Glaser 1998, p. 43), whereby the researcher "decides which data to sample next in the data collection process". This deduction is based on what the data has to date indicated regarding conceptual elaboration.

One of the assumptions underpinning grounded theory is that human existence is characterised by latent patterns of behaviour (an issue or concern) of which people are not conscious (Glaser 1978, 1998). The goal of grounded theory therefore is to account for those patterns and the relationships between the patterns. This means that the theory generated by the researcher, has to emerge from the data and "explain conceptually" what strategies participants use to recurrently resolve their main concern (Christiansen 2008, p. 22). Glaser (1978, p.3, 1998, p. 22, 2001, 2003)

stresses that the outcome of a grounded theory is not findings or merely the reporting of facts, but instead the generation of “probability statements’ or a set of integrated ‘conceptual hypotheses” developed from empirical data. As a generative and emergent methodology, grounded theory therefore requires the researcher to enter the research field with no preconceived problem, interview protocol or detailed review of the literature (Glaser 1978, 1992, 1998, Holton 2009). This is in contrast to other versions of grounded theory as well as other qualitative methodologies, which emphasise a priori particular theoretical perspective, preconceived professional interest, interview schedule and an extensive review of extant literature. Instead, in grounded theory the researcher needs to remain open to exploring a substantive area and allowing the participants’ concern or problem to emerge. This also means that the researcher refrains from pre-defining the problem, fitting the problem into an existing theoretical framework or from “knowing’ before he/she is in a position to “know” (Christiansen 2008, p.23). Using the procedural, albeit flexible steps of grounded theory is what Glaser (1998, p.220) calls a “full package” experience and a “delayed action phenomenon” (p.2). As an approach, grounded theory is not linear; the generated theory develops during the research process itself which is concurrent, iterative and integrative and is a product of the continuous interplay between the analysis, conceptual theorizing and data collection from the outset of the research study (Goulding 2002, Duhscher & Morgan 2004).

Although classic grounded theory emerged from the objectivist epistemology, Glaser (1998) was reluctant to categorize grounded theory into any one overarching paradigm believing that it would distort the true emergence for theory generation. He argues that grounded theory is a general research methodology, which he describes as both a methodology and method, and as such the epidemiology is irrelevant; Glaser (2007, p.27) states, “it’s how you use it”. Classic grounded theory is therefore not confined to any particular epistemological or ontological perspective but instead can adopt any philosophical perspective embraced by the researcher or appropriate to the data since latent patterns are everywhere (Glaser 1998, 2001, 2007). Notwithstanding this, other researchers often associate grounded theory with various theoretical perspectives, most consistently symbolic interactionism (Annells 1996, Goulding 2002, Holloway & Wheeler 2002, Mc Cann & Clark 2003, Clarke 2005). Symbolic interactionism theory as described by its original founders George Herbert Mead (1967) and Herbert Blumer (1969) is an approach to understanding

and explaining society and the human world. The tenets of symbolic interactionism are based on the belief that humans should be considered in the context of their environment. People, individually and collectively behave and interact based on how they interpret or give meaning to their world; therefore the individual and the context in which they exist are inseparable (Benzies & Allen 2001). As a theoretical perspective, symbolic interactionism informs a range of methodologies, including some forms of ethnography.

Both Glaser (2005) and Holton (2008) argue that one of the dominant preconceptions regarding grounded theory is the frequent attribution of its roots to symbolic interactionism. Whilst acknowledging Strauss' influence and contribution to the methodology, they point out that it is important not to ignore the fundamental influence of Glaser's training in quantitative methodology. Martin (2006, p.122) echoes this and points out that it was Glaser's influence which helped to develop the analytic techniques "that gave qualitative researchers tools for systematic analysis". Holton (2009, p.38) also adds that pre-framing grounded theory through the theoretical lens of symbolic interactionism not only precludes other perspectives but also predetermines what data are to be used and how they should be collected, which is antithetical to the tenets of classic grounded theory. She stresses that classic grounded theory should not be confined to any one lens. As Glaser (2005) argues, classic grounded theory is not a methodology guided by one theoretical perspective (Glaser 2005)

Viewed as a distinct general methodology, classic grounded theory stands on its own as a conceptual theory generating methodology. It does not fit within the established qualitative or quantitative paradigms and can be used with any data – qualitative, quantitative or a combination (Glaser 2005, p.141, Holton 2009). Although often labelled as a qualitative approach, Glaser (1998, 2001) argues that grounded theory is not solely a qualitative method; "it just uses qualitative data mostly - but among many possible data". For Glaser (1998, 2003, p.99) the basic tenet "all is data", which is not applicable to other qualitative descriptive methodologies, allows the researcher to use all types of data and in any combination because all is data for generating theory. As Glaser (1992, p11) states "it's all data for the analysis, whether soft or hard, it is just grist for the mill of constant comparison and analysing".

With many prominent researchers writing on methodology and mixing qualitative data analysis methods and grounded theory, Glaser (2003) argues that the goal of conceptual theory generation is often eroded in favour of conceptual description. He believes that as a result, there is often methodological confusion and remodelling by default of the original methodology into qualitative data analysis, with an emphasis on coverage, description, accuracy and member checking. According to Glaser (2003) the goal of grounded theory is theoretical completeness not descriptive coverage. Glaser (1998, 2001) uses the following four inter-related criteria for judging a 'good' grounded theory, it should 'fit' the phenomenon, be of 'relevance' to the participants, it should 'work' and provide an explanation of the phenomenon and be 'modifiable' as new data are incorporated. Glaser's continuing concern with the impact of various subsequent 'remodeling' of the original methodology has motivated him to produce several additional publications (Glaser 2001, 2003, 2005); his 2003 publication in particular, distinguishes grounded theory as a general research methodology.

Since the disagreement between its founders, grounded theory has continued to evolve and has become an extensively applied research approach. Other approaches to grounded theory, for example Clarke's (2005) version based on situational analysis and Charmaz's (2003, 2006) constructivist grounded theory, which will be discussed later in this chapter, are apart from their name fundamentally different from classic grounded theory (Christiansen 2008). While some writers would suggest that there are multiple versions of grounded theory, each with a family resemblance, Glaser has argued that as they differ sufficiently from the original methodology they serve a different purpose (Bryant & Charmaz 2007). Furthermore, to mix methods of these different versions of grounded theory with Glaser's is not possible as McCann & Clarke (2003) point out, depending on the researcher's ontological and epistemological beliefs there are also several areas of divergence concerning its methodological development and application. Notwithstanding this, engaging in any form of grounded theory study involves the researcher addressing a set of common characteristics in the varying stages of the study. As an evolving research method, Glaser's (Glaser & Strauss 1967, Glaser 1978, 1998, 2001) classic grounded theory has to be considered as a fundamentally different methodology, which comprises specific and essential characteristics. These characteristics will now be discussed.

Grounded Theory as a research method: Essential characteristics of Glaser's Grounded Theory

In starting any study, consideration of the methodological principles is essential. As stated earlier, classic grounded theory as a methodology provides a total package, which comprises a set of established principles for conducting research, interpreting data and taking the researcher from data collection through several stages to a theory within a scheduled period of time (Glaser 1998). The essential elements that constitute classic grounded theory methodology are described in Glaser's texts (Glaser 1978; 1992; 1998; 2005); he stresses that a study can only be considered as a true theory when the complete grounded theory package is utilized. In fact, he states that if the researcher wishes to produce a "quality theory" with conceptual density then none of the essential components can be omitted (Glaser 1978, p.16). The essential methodological features of grounded theory consist of the following; coding, constant comparative analysis, theoretical sampling, memoing, theoretical sensitivity and the use of literature. Grounded theorists use these analytical and reflexive features to aid the process of generating theory. Each feature has a specific purpose and their use is guided by the emerging theory, yet they are interconnected and provide an integrated approach to data collection and analysis. As a methodology, grounded theory is concurrent and iterative with data collection, analysis and conceptual theorizing occurring simultaneously and from the outset of the research study (Boychuk Duckscher & Morgan 2004). The process of generating theory is one of deconstruction and reconstruction of the data, and the principal strategy for achieving this is the constant comparative method of analysis (Glaser & Strauss 1967), which begins with a process of coding.

Coding

Conceptualization of data through coding is the foundation of grounded theory development (Holton 2008). Grounded theory researchers analyse data from the outset. Coding and categorizing goes on throughout the research study and is the process by which categories and their properties are generated. As stated, the process of coding does not occur in isolation and is inextricably linked to all phases of the method. In grounded theory there are many conceptual levels. According to Holton (2008) a conceptual code provides the essential relationship between data and theory. Codes are shorthand analytic labels or names that the researcher gives to

specific pieces of data. Incidents in the data are analysed and coded. In classical grounded theory (Glaser 1978), the coding process involves two types of coding:

1. Substantive coding
2. Theoretical Coding

Substantive and theoretical coding are used to build the conceptual theory and result in the formation of categories and properties of the theory.

Substantive Coding

Substantive coding refers to the process of coding the ideas or incidents emerging from the data and result in the formation of categories and properties of the theory. Substantive codes can be “in vivo”, in that they are taken from the language of the participants (Glaser 1978, p.55) or “in vitro”, constructs by the researcher to reflect the data (Strauss 1987, p.33). Substantive coding comprises two types of coding; namely: open coding and selective coding.

Open coding

In grounded theory, the goal of the researcher is to generate “an emergent set of categories and their properties that fit, work and are relevant for integrating into a theory” (Glaser 1978, p.56). To achieve this, the researcher begins with open coding which sets the initial stage to move conceptualization to a higher level. Open coding is the first step in the constant comparative analysis, which aims to discover as many tentative categories and their properties as possible (Glaser 1978, 1992). The term open coding referred to by Glaser (1978) and Strauss and Corbin (1990, 1998) is synonymous with that of initial coding, the name used by Charmaz (2006), and involves the researcher breaking their data into analysable fragments and defining their meanings through using codes. According to Glaser (1978) open coding breaks down or “fractures the data” (Glaser & Strauss 1967, p.108), and helps the researcher to determine which direction the research is heading and inform the theoretical selection of future sources of data.

When coding, Glaser (1978, p.57) poses three questions to be asked of the data while Charmaz (2006, p.47) adds a fourth question.

1. What is this data a study of?
2. What category does this incident indicate?
3. What is actually happening in the data? (Glaser 1978)
4. From whose point of view? (Charmaz 2006)

Glaser (1978) and Charmaz (2006) advocate the use of line by line coding which ensures adequate coverage of the data and assists in the development of categories that are grounded in the data. According to Glaser (1978), open coding comprises “coding the data in every way possible....running the data open” (p.56). With open coding, the researcher moves quickly to open up the data, to compare incident with incident, identify and name beginning patterns, as well as begin the process of comparison between the codes applied. However Glaser (1978, p.58) warns against moving too quickly towards an ‘overview approach’ to data analysis and as a result risk the possibility of missing important concepts that may only be identified after prolonged and intense engagement with the data. In grounded theory the emphasis on analysing processes begins with using gerunds for coding; the noun form of a verb which preserves action by stating what people are doing. Charmaz (2006) argues for the use of gerunds when coding as a way of identifying the process in the data as well as focusing on the participant’s experience as a source of conceptual analysis. Gerunds also facilitate making connection between data and between codes. Coding is an active process drawn from the substantive area of investigation, the researcher’s knowledge and experience, and extant theory. Both Glaser (1992) and Charmaz (2000) reject vehemently the use of a coding paradigm at this stage, such as the one described by Strauss and Corbin (1990) as a useful tool to analysis; they believe that it will force the data into theoretical framing influenced by the researcher rather than allowing theory to emerge from the data.

Selective coding

For Glaser (1978) open coding is followed by selective coding, where the researcher will begin to code in relation to the developing theory and core category. Selective coding begins only after the researcher is sure that she/he has discovered the core variable or core category. The researcher ceases open coding and delimits coding to only those variables that relate to the core variable and associated categories in

sufficiently significant ways to produce a parsimonious theory (Glaser 1978). This means that coding and theoretical memos become focused on aspects of the core category.

Theoretical coding

Theoretical coding is a sophisticated level of coding which generates meaning and scope to the emergent theory and involves conceptualizing the relationship between categories. According to Glaser (1978) theoretical codes in contrast conceptualize how the substantive codes may relate to each other when integrating the theory. They are what Glaser (1992, p.38) describes as “conceptual connectors” that develop relationships between categories and their properties. Similar to substantive codes theoretical codes must be emergent in the data and earn their way into the theory. Their purpose is to “weave the fractured story back together again” (Glaser 1978, p.72). Theoretical codes are much more abstract than substantive codes and therefore provide a way of thinking about the data in theoretical rather than descriptive terms. Glaser (1978, p73) states that researchers must be sensitive to “the myriad of implicit integrative possibilities in the data”. To assist in the process of theoretical coding, he provides a listing of over 40 theoretical coding families (Glaser 1978, p.73-82, 1998, p.170-175, 2005, p.7-30) that may be used to integrate the theory. One of these codes he called the ‘range model’ , which is a simplified version of the more complex 6 C’s family of theoretical codes: cause, context, contingencies, consequences, co-variance and condition, which is used by Strauss and Corbin in their approach to grounded theory (Glaser 1978, p.74).

Other examples of theoretical codes include; a process, a condition, two dimensions, a typology. These coding families sensitize the researcher to the array of behavioural patterns by which they weave their data back together into a parsimonious grounded theory. However, these coding families are proposed only as a set of lenses or perspectives through which the researcher might view the data. Glaser (1992) advises that over reliance on one theoretical code, as exemplified by Strauss and Corbin’s reliance on the 6 C’s theoretical code, leads to a destructive forcing of data into a pre-existing framework, which is contrary to the whole Grounded Theory process. In addition, Glaser (2005) stresses that whichever theoretical code is adopted during the process of theoretical coding; it is imperative to allow the data to determine which code best fits the data.

Constant comparative analysis

A fundamental characteristic of grounded theory is the use of the constant comparative analysis of data, which guides the development of the grounded theory (Glaser & Strauss 1967). Constant comparative analysis occurs during simultaneous data collection and analysis, is underpinned by theoretical sensitivity and memoing, and refined by theoretical sampling (Charmaz 2006). As a core ongoing activity, constant comparative analysis begins after the first pieces of data are collected and ends at the write-up stage. Essentially, constant comparison is the process of constantly comparing instances of data that you have labeled as a particular category with other instances of data that you have labeled as a particular category to see if the categories fit and are workable. Throughout the grounded theory process, constant comparative analysis involves comparing incident to incident, incidents with category and category with category to generate concepts (Glaser 2001). This comparative process looks for similarities, differences or varying conditions and continues until the emergence of the core category. Initially the researcher starts by coding each incident in the data. Constant comparison of incident with incident leads to the initial generation of codes or concepts. Essentially concepts are units of data that are more advanced than codes and aim to explain the relationship between and across incidents (Goulding 2005). Using constant comparative analyses, memoing and theoretical sampling the researcher attempts to build on these concepts and build on their properties. Glaser (1998) describes a property as a conceptual aspect or element of a category. Future codes are then compared with existing codes, groups of codes are collapsed into categories with which future codes are then compared and categories are subsequently compared with categories. A category is a higher level concept than a property, stands by itself as a conceptual element of the theory and captures the underlying patterns in the data. Categories are then developed and group together the relevant concepts that articulate the particular phenomenon. Iteration is a feature embedded within the principle of constant comparison analysis (Glaser & Strauss 1967). With repeated data collection and constant comparative analysis categories are then either refuted as being irrelevant or they become saturated and form part of the emerging theory. For Glaser (1998) this repetitive process of moving back and forth between data and the theory helps the researcher to compare and contrast data, elaborate theoretically, saturate and verify the emerging interpretations and concepts during each stage of the analysis.

According to Charmaz (2006) the use of constant comparison analysis assists the researcher in demonstrating the analytic development of the grounded theory. Coding and constantly comparing data requires the researcher to think inductively. Inductive thinking requires the researcher to stop the coding process and write memos which captures their thoughts, hunches, and interpretations about the situation at that time (Glaser & Strauss 1967). As the theory develops the delimiting features of selective coding and the constant comparative method help reduce and focus the theory. For Glaser and Strauss (1967) delimiting the theory occurs at two levels, the theory and the categories. Firstly as the theory emerges, the researcher identifies similarities in concepts and therefore the number of concepts for coding is reduced. In addition, as the theory develops the researcher begins to focus on the core category and related variables. Delimiting of the theory also occurs through the process of theoretical saturation of a concept. Saturation occurs when no additional information is being obtained, whereby the researcher can develop properties of a category, therefore the category has earned its way into the emerging theory (Glaser 1998). The constant comparative method together with the use of memoing that document the researcher's ideas as coding proceeds, theoretical sampling and sorting, which organizes the data and the memos are the essence of Glaser's (1978) method. Using this comparative method is a dynamic non-linear process, requiring the researcher to stay open to new insights within the analysis.

Theoretical sampling

Theoretical sampling, a unique feature of grounded theory is an active and ongoing process that controls and directs data collection and analysis (Charmaz 2000). Sampling in grounded theory is described as theoretical rather than purposeful as it is driven by the emerging theory (Cutcliffe 2000). To sample theoretically is an integral part of the development and refinement of a theory that is "grounded in data" (Breckenbridge & Jones 2009, p. 113). Engaging in theoretical sampling involves the researcher making a strategic decision about "what data to collect next, where to find them and for what, in order to develop his/her theory as it emerges" (Glaser 1978, p. 36). Simultaneous collection and analysis of the data, together with the emerging theoretical structure is an ongoing process that guides the direction of further sampling throughout the study (Alvesson & Skoldberg 2000). However, given the inductive nature of grounded theory and unlike other sampling methods, which are planned prior to commencing the research study theoretical sampling continues

throughout the study and cannot be predicted in advance. Researchers using theoretical sampling therefore do not know precisely who or what to sample for or state the exact number of potential participants before the study begins since the data analysis procedures directly affect the sampling procedures. Nevertheless, in the initial stages of a grounded theory study the researcher must have some idea of where to sample and usually begins with a purposeful sampling strategy aimed at a particular group of individuals who are able to provide information on the topic under study. Following analysis of data from the purposeful sample the researcher then proceeds to theoretical sampling, whereby sampling procedures become more refined and focused as the grounded theory emerges (Coyne 1997). Sampling in grounded theory is therefore sequential starting with purposeful sampling before moving into theoretical sampling when data analysis begins to yield theoretical concepts, which direct further sampling (Draucker *et al* 2007).

According to Sandelowski (1995) theoretical sampling has often been misconstrued as inter-changeable with purposeful sampling. Theoretical sampling differs from purposeful sampling in that the latter involves the researcher making a calculated decision where to sample based upon preconceived ideas about the research question (Cutcliffe 2000). In contrast, theoretical sampling in grounded theory is strategic, specific, and systematic, and involves selecting groups as and when they are needed rather than before the research begins (Glaser 1992). While a purposeful sample is selected at the outset of the study for a predetermined purpose, theoretical sampling progressively and systematically directs data collection to serve the emergent theory. Theoretical sampling is therefore always purpose-driven; the sample is selected for the purpose of explicating and refining the emerging theory as opposed to creating a descriptive account. However as Hood (2007, p. 158) succinctly points out while all theoretical sampling is purposeful, “not all purposeful sampling is theoretical”. As stated earlier, theoretical sampling is intertwined with the abstraction of description into theory and is crucial to discovering and refining categories and their properties and suggesting relationships between concepts. Theoretical sampling involves the researcher recruiting new participants with differing experiences of the phenomenon or observing new settings and /or asking earlier participants further questions about experiences not covered previously, in order to explore the multiple dimensions of the social processes under study. As categories emerge from the data, the researcher must ask “what groups or subgroups does one turn to next in data collection and for

what theoretical purpose”? (Glaser & Strauss 1967, p.47). The answer to this question lies in the categories that have been generated which have emerged from the data. The researcher samples for both theoretical similarity and difference in order to explain, elaborate and refine a category or to test the validity of a category (Glaser 1978). Another unique factor about theoretical sampling is that it is not just about sampling people; it also includes modifying data collection procedures, in particular the type of interview questions as the study progresses (Draucker *et al.* 2007) as well as, returning to previously collected data to look for what Glaser & Strauss (1967, p.72) described as a ‘sample of categories’.

Theoretical sampling relates only to conceptual and theoretical development; it is not about representing a population or increasing the statistical generalisability of the results. In grounded theory it is the quality of the data and not the frequency it occurs that is important (McCann & Clark 2003). The researcher continues to sample theoretically until theoretical saturation is reached, that is when no new codes are identified in the data and the complete range of constructs that make up the theory is fully represented by the data. At which time coding is of a more advanced nature and the researcher seeks extant theory to add explanatory power to their integrative grounded theory. The sample selection is therefore not based on the continual selection of participants from a homogenous group. When the core category is saturated and data collection no longer generates new leads theoretical sampling will then cease (Glaser & Strauss 1967). Completeness is based solely on “theoretical completeness” rather than the number of interviewees or lengths of interviews (Glaser 1998, p.159). As stated earlier, the sample size is considered to be satisfactory only when the key concepts that have been identified from the collected data have reached saturation.

Theoretical memos

Memos, another important feature of grounded theory are defined by Glaser (1978, p.83) as “the theorizing write-up of ideas about codes and their relationships as they strike the analyst when coding”. Glaser (1978, 1992) strongly recommends the writing of memos as part of the process of developing grounded theory. Memo writing occurs throughout the grounded theory process. As a core ongoing activity, writing memos is a pivotal analytic stage between data collection and write-up and involves the detailed capturing of the researcher’s thoughts, hunches, interpretations

and decision-making throughout the analysis (Tweed & Charmaz 2012). As such, the process of memo writing articulates or maps out the grounded theory journey by capturing every idea that the researcher might have from the early stages of the study to the development of the emergent theory. Memos also assist with the development of abstraction as well as helping the researcher to discover ideas about the data; they can alert the researcher to under-developed areas of theory, gaps or hypotheses requiring elaboration or testing. Charmaz (2006) argues that without memos the researcher will not be able to engage in theoretical sampling or be able to advance their skills in theoretical sensitivity. Theoretical memos connect the stages of the analytical process with the generated theory and lead naturally to abstraction or ideation (Glaser 1978). Writing memos therefore establishes an audit trail and proof of the researcher's developing theoretical sensitivity and the research process enabling the recording of the analysis as it takes place from the outset of the study (Birks & Mills 2011).

Although Glaser (1992) and Strauss and Corbin's (1990 p.197) definition of memos the "written records of analysis related to the formulation of theory" are similar, Glaser questions their idea of categorizing memos into various types, which he believes not only undermines the trust in grounded theory but also moves the analysis to full conceptual description as opposed to grounded theory. Memos serve a number of purposes which are particularly significant in advancing the researcher's analysis. According to Glaser (1978, 1998) the goals of memoing are:

1. To theoretically develop ideas
2. To complete the first goal with freedom
3. To maintain a memo fund

Memos help the researcher to take data to a conceptual level (Glaser & Holton 2004) and are in constant development throughout the development of the emergent theory. As described above, constant comparative analysis encourages the process and development of memoing as the researcher articulates the decisions he/she makes concerning the data. While the codes and categories are either refuted or continued to saturation, memo-writing will give rise to further memos and re-writing of previous memos (Glaser 1978). As memos accumulate and mature they increase to the point of saturation and the need to be sorted for writing up.

Glaser (1978, p.89) provides “memoing rules” to assist the grounded theorist with keeping and sorting of memos, these include the following:

- Keep memos and data separate
- Always interrupt coding and data recording to write a memo
- Memos can be brought on by thinking and writing about a code
- Be prepared to modify and rewrite memos
- Keep a list of the emergent codes
- Collapse memos if the codes appear similar

The process of memoing also addresses the issue of subjectivity and the potential for researcher bias. Memoing therefore has a dual purpose of being part of data analysis and in countering subjectivity which enhances the likelihood of producing accurate research findings (Elliott & Lazenbatt 2005). While memoing begins and continues during collection, coding and analyzing of data, and peaks as coding saturates, Glaser (1992) points out that it does not end until the final draft is complete. Memo-writing in tandem with the constant comparison process therefore continues throughout and informs the whole research process.

Theoretical sensitivity

Another key concept of grounded theory is the researcher’s acquisition of theoretical sensitivity (Glaser 1978). The concept of theoretical sensitivity was developed in 1978 by Glaser and was put forward to help researchers to relate their analysed categories into theory (Glaser 1978). Theoretical sensitivity is a multidimensional concept and an important attribute, which comprises the researcher’s ability to work with the data in both theoretical and conceptual ways (Glaser 1978). This means that the researcher can theoretically and conceptually think about the data from a distance, while at the same time “maintain an in-close level of sensitivity and understanding about the research process and their involvement in that process” (Walker & Myrick 2006, p.552). Glaser (1978) believes that researchers must be theoretically sensitive in order to contribute to the development of grounded theory. Birks & Mills (2011 p.58) echo its importance and advise that “failure to embrace it fully will result in a shallow product”. They also point out that a researcher’s level of theoretical sensitivity is deeply personal and reflects his/her personal and professional history. Given its intangible nature, theoretical sensitivity is a difficult concept to grasp. Glaser (1978) acknowledges that no researcher approaches a study

with a totally blank sheet as they have their own disciplinary training that provide perspectives from which to investigate the problem; however he points out that the researcher may knowingly or unknowingly apply their preconceived ideas and theory onto the data. In order to understand and acquire theoretical sensitivity, it is therefore important for the researcher to be aware of his/her own assumptions before embarking on a grounded theory study (Birks & Mills 2011).

Recognizing the challenges of acquiring theoretical sensitivity Glaser (1978) offers some strategies that may enhance the researcher's ability to become more theoretically sensitive to the data. Theoretical sensitivity is attained through immersion in the data, the ongoing process of constant comparative analysis and the use of memoing, all of which play an important role in limiting distortion during analysis by sensitizing the researcher to his/her personal biases (Glaser 1992). These processes help to validate, alter or reject the researcher's observations and therefore minimize the potential for bias. Theoretical sensitivity is also built up over time, from reading and experience, professional and personal which guides the researcher to examine the data from all sides rather than stay fixed on one perspective and/or the obvious.

For Glaser (1978) developing theoretical sensitivity requires creativity whereas Charmaz (2006, p. 135) describes it as "theoretical playfulness". Charmaz suggests that the researcher's sensitivity is attained through stopping, thinking and examining the data from multiple perspectives, making comparisons, and following and building on ideas. To gain theoretical sensitivity the researcher needs to remain open-minded and flexible throughout the process of data collection, analysis and theory writing (Mc Cann & Clark 2003). Charmaz (2006) also points out that the use of gerunds when coding the data fosters theoretical sensitivity because they prompt the researcher to code for action processes rather than coding for topics. In addition, as the researcher becomes immersed in the data their ability to extricate the nuances and subtle differences in the generated data and differentiate between significant and less important data can be built up over time (Glaser 1978). The connection between theoretical sensitivity and modern notions of reflexivity will be explored later in the chapter.

The core category

A central idea in classic grounded theory (Glaser 1978, 1992) is identifying a core category or concept that encapsulates the process apparent in the categories and sub-categories. The core category is a dimension of the research problem; it is the category that explains how the main concern of the participants is persistently resolved. As a central point of a grounded theory study, its primary function is to integrate and conceptualise all the relationships between the substantive codes. Glaser (1978, p. 93) states that a core category will “account for most of the variations in a pattern of behaviour” and that the categories will be related to the core category. The core category is the highest level of categorization; it is the variable that reoccurs constantly in the data and relates to all the other categories and their properties. Similar to theoretical categories, the main aim of the core category is to explain and pull together the other related categories and their properties (Glaser & Holton 2004). The core category emerges gradually through the constant comparison concern process, theoretical sampling and sampling of literature. Once a core category is selected, the researcher will limit theoretical sampling to the generation or collection of data that will theoretically saturate the core and related categories and sub-categories. This in turn helps the researcher to shape his/her grounded theory, refine and fully integrate each theoretical component, while developing the overall level of conceptual abstraction. For Glaser (1992, 2001) the development of a strong, conceptually abstract core category is at the centre of grounded theory analysis and is generalizable; “it has grab, it is often high impact dependent variable of great importance; it is hard to resist; it happens automatically with ease” (Glaser 2007, p14). Researchers tend to see their core categories everywhere’. While a core category is always present in a grounded theory study, and can be a basic social process; this is not always the case (Glaser 1978, p.97).

Constructivist Grounded Theory: Charmaz

Charmaz’s method of grounded theory known as Constructivist Grounded Theory was published in 2000. She states that her version of grounded theory “takes a middle ground between post modernism and positivism, and offers accessible methods for taking qualitative research into the 21st century” (Charmaz 2003, p.250). Constructivist grounded theory (Charmaz 2000, 2005, 2006) adopts grounded theory guidelines as tools but rejects the objectivist, positivist assumptions underpinning its

earlier formulations (Glaser & Strauss 1967, Glaser 1978), which she believes were developed for managing and interpreting the data. Epistemologically, constructivism which underpins constructivist grounded theory asserts that reality is constructed by individuals as they assign meaning to the world around them (Hayes & Oppenheim 1997, Appleton & King 2002). From a constructive stance, meaning therefore does not lie dormant within objects waiting to be discovered, but instead is created as individuals interact with and interpret these objects (Crotty 1998). Critical of the 'objectivist' stance within classic grounded theory, Charmaz (2000, 2006) places much importance on the context of the researcher in the study and the relationship between the researcher and participants resulting in the creation of a shared reality. She argues that researchers do not exist in a social vacuum and are influenced by the relationships and incidents they have with individuals both within and outside of the study. For Charmaz (2006), data and analyses are co-created through an interactive process from "shared experiences and relationships with participants and other sources of data" (p. 130). Constructivist grounded theories are therefore reflexive in design, whereby the researcher is positioned a co-creator of meaning with participants in the generation of data as opposed to being a distant expert (Charmaz 2006, Mills *et al* 2007). The concept of reflexivity in general and its position within classic grounded theory is discussed further later in the chapter.

Constructivist grounded theory is placed firmly in the qualitative interpretative tradition (Charmaz 2006). For the most part, constructive grounded theory follows the stages of the grounded theory methodology; however the end product is not a core category or a basic social process. Instead, constructive grounded theory acknowledges the complexity of individuals and their unique experiences as impacting on the generation of the emerging theory (Charmaz 2003, 2006). Constructivist grounded theorists are encouraged to keep the data alive by using analytical procedures that are true to the experiences of the participants (Mills *et al* 2006), for example, the concept of 'process' is often described as a characteristic feature of grounded theory. However, while Glaser (1978) discusses the specific concept of the basic social process at length and acknowledges that process is possible, he does not consider it an essential, element of grounded theory. In contrast, Charmaz (2006, p.19) believes that process is central and argues that emphasising process during analysis forces the researcher to identify relationships evident in the study. The use of 'gerunds' (the noun form of a verb) are also advocated by Charmaz

(2006) when coding as a means of emphasising the action employed by the participants, which is essential in grounded theory methods.

In Glaser's (2003, p.167) rebuke of Charmaz's (2000, 2003) method, he describes constructivist grounded theory as a "misnomer". With reference to Charmaz's focus on the researcher participant relationship, Glaser (1998, 2003) refers to his well-known grounded theory dictum 'all is data', which he argues incorporates not only what is being told, but also how it is being told and the conditions surrounding what is being told (Glaser 1998, 2003). For Glaser (2003), if the researcher is exerting bias then this is part of the research, it is just another variable which is woven into the constant comparative analysis. Therefore, the classic grounded theory does not necessarily assume the objectivity of the researcher or ignore his/her perspective; instead through the rigorous application of the methodology, researcher biases are revealed and incorporated as more data to be constantly compared (Glaser 1998). Glaser (2003) points out that Charmaz (2000, 2003) not only neglects the inbuilt strategies of the grounded theory method which makes the generated theory as objective as humanely possible but also the fact that the theory produced is conceptual and as such provides abstract distance from the data. Given this, Glaser (2003) believes that Charmaz's (2006) constructivist grounded theory has not considered the properties of conceptualization.

A central tenet of constructive grounded theory is to give voice to participants. However, unlike Charmaz, Glaser (2002) argues that the purpose of grounded theory is not to tell participants' stories, but instead through careful application of all the grounded theory procedures to identify and explain conceptually an ongoing behaviour which seeks to resolve an important concern. Essentially, the findings of a grounded theory study are not about people, but about their patterns of behaviours. Furthermore, the main concern conceptualised in the grounded theory may not have been voiced explicitly by participants; but instead abstracted from the data in which the concern was enacted consistently (Glaser 1998). Notwithstanding the above, Glaser is concerned with participant perspectives; however the key difference is that participant perspectives are explored not from a descriptive or interpretative approach but with an aim to raising these perspectives to a conceptual level (Glaser 2002).

Reflexivity

Reflexivity is widely viewed as a concept of particular importance for qualitative researchers, both as a method and a process in a variety of methodologies (Robson 2002, Dowling 2006, Freshwater 2011). Essentially, reflexivity is concerned with the role of the researcher within the research process. Cutcliffe (2003) asserts that qualitative research is a reflective process, in that ‘the researcher has an impact on the research process and vice versa’ (p. 136). As Hammersley and Atkinson (1983) point out, it is an unavoidable fact that the researcher is an integral part of the social world he/she is studying. For the researcher, “practising reflexivity” in qualitative research therefore involves looking “inwards” and “outwards”, exploring the intersecting relationships between existing knowledge, personal experience, research roles and the surrounding world (King & Horrocks 2010, p. 125). This also requires researchers to be open to their influence on the inquiry prior to entering the field to conduct interviews or observation (Streubert-Speziale & Carpenter 2007).

Throughout the literature, the term reflexivity is used widely and with a diverse range of understandings and formulations of the concept (Cutcliffe 2003). At its simplest, Wilkinson (1988, p. 403) says that reflexivity can be considered as “disciplined self-reflection”; a more detailed definition describes it as the systematic study of the researcher within the research process, whereby the researcher is viewed as being part of rather than separate from the data and using self-awareness as a source of awareness (Boyle 1994). Other definitions of reflexivity also support the activity of self-inspection (Colbourne & Sque 2004) or self-reflection (Carolan 2003). A more recent and similar definition by Birks & Mills (2011, p.52) refers to reflexivity as an active process whereby the researcher “systematically develops insight into his/her work to guide future actions”. This reflective process is often facilitated through techniques such as journaling or being interviewed by another member of the research team. These approaches involve researchers documenting their reflections about their experiences as they participate on multiple levels of involvement within the research context. Gough (2003, p. 25) believes that in general reflexivity tends to focus on revealing what he calls “hidden agenda”, for example the researcher’s bias or assumptions as these will have a direct impact not only on how research is undertaken but also on the whole research process from the beginning to the end. Reflexivity is therefore associated with the various methods and processes that enable researchers to explore and examine their roles and

influences within research projects and through a process of “systematic, critical questioning and appraisal” (Freshwater 2011, p.188).

Etherington (2004) however, argues that researcher reflexivity needs to be discussed beyond the analytic focus on the researcher’s role and towards a consideration of different epistemological perspectives. She believes that reflexivity operates on multiple levels since the researcher is not only intimately involved in the process but also the product of the research study (Horsburgh 2003). Furthermore, Freshwater, Taylor & Sherwood (2008) point out that reflexive researchers’ levels of participation and involvement in the research process can vary both across methods and researchers. For the researcher, being reflexive therefore involves being mindful in the moment of what is influencing his/her internal and external responses, while at the same time being aware of his/her relationship to the research topic and the participants. These positions reflect the two main types of reflexivity - personal and epistemological, which are evident in the literature. Epistemological reflexivity according to Willig (2008) encourages researchers to reflect upon assumptions about the world that have been made in the course of the research, for example how the research question has been defined, method of data analysis; whereas personal reflection involves giving consideration to the way in which the researcher’s beliefs, interests and experiences might have impacted upon the research.

There is general consensus in the relevant literature that the purpose of reflexivity is at least in part, to enhance the credibility of the findings by accounting for the researcher’s values, beliefs, knowledge and biases (Cutcliffe 2003). According to Freshwater *et al* (2008), reflexive transparency aims to reduce the likelihood of imposing the researcher’s preconceptions and/or biases upon any aspect of the research study or process. Researchers need to reflect constantly on their roles and influences in order to bring participants’ accounts of their experiences to the forefront. Furthermore, Primeau (2003, p.9) argues that reflexivity improves the quality of the research process by enhancing researchers’ understanding of how their position and interests affect all stages of the research process. Sharing reflective experiences with readers according to Huberman & Miles (1994) makes researchers more accountable and therefore reflective accounts need to be explicit, detailed and complete. However, writings on reflectivity have not always been transparent in

terms of the practicalities and methods of the process (Dowling 2006). Some of these issues will be discussed in relation the role of reflexivity and grounded theory.

Reflexivity and Grounded Theory

The term 'reflexivity' is not apparent in Glaser and Strauss' early seminal grounded theory text, even though their work had emerged out of the Chicago School of ethnographic fieldwork. Historically, the original grounded theorists paid little attention to the personal qualities of the researcher or their relationships with participants, instead they viewed participants' words and actions as a source of data that they needed to obtain in an objective manner (Glaser & Strauss 1967, Glaser 1978). As stated above, more recent constructivist applications of grounded theory have challenged this stance, promoting instead a position of mutuality between researcher and participant that acknowledges the researcher's voice in the final product (Charmaz & Mitchell 1996, Charmaz 2006, Mills *et al* 2006.). Charmaz (2006) believes a reflexive stance allows the reader access to how the researcher conducts his/her research, relates to the research participants and presents them in written reports. Similarly, Birks and Mills (2011) believe it imperative for grounded theorists to be reflexive researchers, regardless of their methodological position.

In classic grounded theory (Glaser & Strauss 1967, Glaser 1978, 1992, 1998) the emphasis on researcher reflexivity that is founded in other qualitative approaches is not highlighted in an explicit manner. Notwithstanding this, early literature suggests that reflexivity is embedded within the development of theoretical sensitivity (Glaser 1978, Glaser 1992). As McLeod (2011) posits it is unlikely that a researcher could acquire or develop sufficient theoretical sensitivity without being able to reflect on his/her biases and assumptions. Mallory (2001) considers reflexivity to be inherent in the grounded theory method and while not typically associated with reflexivity, the following characteristics of classic grounded theory facilitate the transparency of the reflexive process throughout the research process. In grounded theory, the research problem and questions regarding the problem should emerge from the data (Glaser 1992). Therefore as stated earlier, one of the first tenets of theoretical sensitivity is to enter the research setting with as few predetermined ideas as possible (Glaser 1978). This requires the researcher to think about and openly acknowledge the influence of

his/her prior work, life experiences or reading on their perspective, as well as any professional or pet interests.

For Glaser (1978) adopting a reflexive approach to data analysis helps the researcher to avoid subconsciously applying his/her pet theoretical codes during initial coding. As stated earlier, the ongoing process of constant comparative analysis and the use of memoing, also play an important role in limiting distortion during analysis by sensitizing the researcher to being continuously open to and vigilant about his/her personal biases, and any non-grounded ideas about the theory (Glaser 1992). As Glaser (1998, p.182) points out, during constant comparative analysis, the researcher may experience ‘non-grounded ideas occurring from personal biases, personal experiences of an idiosyncratic nature’. Consequently, Glaser (1998, p.120) advocated the researcher “to interview him/her self and to use the outcome as another source of data within the constant comparative process”. Neill (2006) agrees with Glaser and argues that the potential impact of the researcher on the data needs to become part of the research record in order to be explored through constant comparative analysis. Memoing also provides another strategy which can help researchers to delve deeper and increase their awareness of their potential influence and impact on the data throughout the grounded theory process (McGhee, Marland & Atkinson 2007). As stated earlier in the chapter, writing memos therefore serves the function of countering subjectivity (Elliott & Lazenbatt 2005).

All of the above strategies help the researcher to engage in the reflexive process, whereby they can set aside their a priori knowledge and assumptions and attend to the analytical goal with an open mind. However, the above processes require the researcher to have an awareness of self and engage in a consciously reflective process; yet as Cutcliffe (2003) points out awareness of self can only be partial. While acknowledging that ‘reflexivity is an ideal and not a goal reached’, it is still important that the researcher does his/her best “to be disciplined and to delve deeper” (Kezar 2003, p.401). However, Glaser (2001) in his later writings advises against the excessive use of reflexivity. He argues that it is a distraction from the proper focus on data and stifles creativity, and as a result produces a descriptive rather than a theoretical account. He also believes that reflexivity will lead to “reflexivity paralysis” in relation to analysis (Glaser 2001, p. 47). Notwithstanding his criticisms against the process of “reflexive paralysis”, Glaser’s position suggests that he is not

rejecting the need for researchers to be reflexive in the sense of being self-aware, but instead he rejects the researcher's desire for introspective compulsion and/or to locate their work within a particular theoretical context (Mc Ghee *et al* 2007), and as such turn the study into an auto-ethnography rather than a grounded theory.

As a psychotherapist and clinical supervisor, I am familiar with the concept of reflexive practice, its application and value, particularly in the context of clinical supervision, which is in itself an interpersonal, reflexive learning process between a supervisor and supervisee (Carroll 1996, 2007, 2010, Milne 2007). Whilst I recognise that my biography and awareness of self may not be central to the research process, it is inherent in everything that I do as a researcher (Marchbank 2005). Similar to my role as a clinician and clinical supervisor, I believe it my responsibility as a researcher to be as aware as much as I can, of my own assumptions and more importantly how they might influence and impact on the research process, to critically analyse them and use my awareness albeit incomplete, to enhance my work as a researcher. As Hardin (2001, p.13) concludes the ability to perceive ourselves as recipients of "somebody else's gaze is related to our ability to reflect on our own behavior, as if we are gazing and monitoring ourselves".

In addition to using the above strategies, in particular the constant comparative process, writing memos and consulting my academic supervisor, I also utilised other reflexive practices such as clinical supervision during data collection and analysis. Practising reflexivity in this context also helped to bring material that was unconscious to conscious, such as, my initial confusion and anxiety concerning the blurring of roles and boundaries between that of clinical supervisor and researcher. Having the opportunity to think about, explain and examine such issues also helped to enhance my ongoing analytical awareness of self, known within the supervisory field as developing one's own "internal supervisor" (Casement 1985, p. 29), and in this context, my reflexivity as a researcher. Examples of my reflexive processes throughout this grounded theory study are illustrated in the next chapter on operationalising classic grounded theory methodology.

Philosophical and methodological underpinnings of this study

Choosing and developing a philosophical methodological position for this study involved struggling with many different views and approaches. Learning to understand and grasp new and complex concepts and philosophies took time and patience, and left me feeling confused, frustrated and at times overwhelmed. The position adopted for this study was informed by constructionism an epistemological position, which means that human knowledge or meaning is not found or discovered; it is constructed by human beings as they engage with the world they are interpreting. In this study, data was produced from the shared experience of the participants and myself as researcher during the interviews. This study is predominantly based on Glaser's method of grounded theory but is influenced by tenets of Charmaz's constructive grounded theory, which I considered as providing added value and not positioning them in opposition but instead as complementing each other. As a researcher and clinician I was conscious of the importance of not losing the voice of the participants as posited by Charmaz (2000). However, using Glaser's theory, I was mindful that the purpose of grounded theory is not to tell participants' stories, but instead to identify and explain conceptually the participants' ongoing behaviour, which seeks to resolve an important concern. In addition, the main concern conceptualised in the grounded theory may not have been voiced explicitly by participants; but instead abstracted from the data in which the concern was enacted consistently (Glaser 1998). Notwithstanding the above, Glaser is concerned with participant perspectives; however the key difference is that they are explored not from a descriptive or interpretative approach but with an aim to raising these perspectives to a conceptual level (Glaser 2002). The theory produced predominantly through Glaser's approach to Grounded Theory represents only one interpretation and not a representation of the world; however, it still provides valuable data on social phenomena. Nonetheless, issues concerning the validity or trustworthiness of the findings cannot be ignored. As a researcher, I was therefore concerned with the criteria for evaluating the validity of a Grounded Theory study including fit, relevance, workability and modifiability (Glaser 1978). These criteria will be addressed later in the final section of the thesis.

Summary and conclusion

This chapter outlined the main epistemological, ontological, theoretical and methodological assumptions that have shaped and informed this research study. At

the outset, the philosophical underpinnings of social constructionism were highlighted. Following this, I explored the development and methodology of Grounded Theory, in particular Glaser's Theory which is used in this study. Within this discussion, the key methodological features that are unique to a classic Grounded Theory methodology are presented. I also highlighted what I understood to be the central tenets of Charmaz's version of grounded theory and how it added to the decisions and processes made when undertaking this study. Within this chapter I also set out to present the role of reflexivity in qualitative research in general and Grounded Theory in particular. Drawing on the the inherent strategies in classic Grounded Theory I highlighted how they helped the researcher to remain open and reflexive in relation to their possible impact on the study.

The following chapter draws on the ideas presented in this chapter and discusses how they were operationalised in the decisions made and the processes implemented in this study.

Chapter Five: Operationalising Grounded Theory

Methodology

Introduction

This chapter discusses how I undertook this research study. The chapter begins with an outline of the overall aim of the study and a brief description of the research setting. This is followed by an account of how I negotiated access, conducted data collection and applied analytic processes through the constant comparative method. The chapter concludes with a description of the ethical issues involved in this study and how these issues were addressed. Although the various procedures and stages of carrying out this study are presented as a linear path of progression, in practice this was not the case. In undertaking this study, I engaged in several sets of what Glaser (1978, p.16) refers to as “double-back steps”, which comprised revisiting the sampling, data collection and data analysis processes, combined with, revising and editing my previous work as I gained greater clarity and understanding. Learning to master the steps of moving forwards and backwards demanded time, patience and perseverance; whereby I acquired not only knowledge and skills but also confidence in my development as a novice researcher in Grounded Theory. In choosing the Grounded Theory method, my main concern was to perform good research while learning-by-doing. This chapter focuses on my reflections of this experiential process of learning, the challenges and opportunities that I encountered and how they were addressed.

Aim of the study

In a Grounded theory study, the research question is not a statement that identifies the phenomenon to be studied. Instead, the research problem and questions regarding the problem should emerge from the data (Glaser 1992). It is therefore impossible to ask a specific and accurate research question before starting any grounded theory study (Hutchinson 2001). For the grounded theory researcher, this then means entering into an area of interest with no problem, but instead with “the abstract wonderment” of what the participants’ main concern is and how it is handled or resolved (Glaser 1992, p.22). Notwithstanding this, given the broad subject area for this study I believed it was important to have one overall aim which would help to focus the research at the early stage of this study. The overall aim of this study was

to examine how mental health nurses respond to clients who present with suicidal behaviour. Similarly, I was also aware that identifying specific objectives was not appropriate for a grounded theory study; however, for the purpose of submitting the proposal to the respective research ethics committees, the following objectives were developed which I believed were sufficiently broad and flexible to explore the phenomenon in depth and allow for the participants' main concern to emerge. The objectives of the study were as follows:

- (i) To explore how mental health nurses conceptualise suicidal behaviour in the context of mental health nursing practice
- (ii) To elicit how mental health nurses respond to clients who present with suicidal behaviour
- (iii) To identify the factors that influence the way mental health nurses respond to clients who present with suicidal behaviour

The research setting

The research setting for this study comprised a mental health service in a large urban area in the Republic of Ireland. The catchment area is one of the largest in the country with a socially and economically varied population of approximately 253,118 (Mental Health Commission Annual Report 2006). The service provides a range of adult psychiatric in-patient and community based services including; admission wards, high observation unit, day hospitals, day centres, community residences as well as community based mental health teams which incorporate home care teams. It has one of the lowest in-patient bed availability in the country, which is attributed to its extensive and progressive development of community based services over the last twenty years (Daly & Walsh 2009). At the time of collecting the data, 260 nurses with a diverse range of clinical experience and qualifications were employed in the service (Mental Health Commission Annual Report 2006). The service was affiliated to a third level academic institution and provided both undergraduate and post-graduate education for nurses, doctors and other allied mental health professionals including psychologists, social workers and occupational therapists. In keeping with their mission statement, the service aimed to achieve the best quality of life for people experiencing mental health problems through the provision of a comprehensive, integrated, high quality and patient-centred Mental Health service. It also endeavoured to tailor their services to provide the most appropriate responses to meet the needs of the patients and their families.

Negotiating access

Gaining permission to access the research site occurred with relative ease. Access to the research site was negotiated with the local ethics committee and service management. At the beginning of the study, I had an informal meeting with the Director of Nursing for the Mental Health Service affiliated to the researcher's University, to discuss the proposed study and to seek support. A letter outlining the study and requesting the nomination of a gatekeeper, together with a copy of the research proposal was subsequently forwarded to the Director of Nursing and Core Management Team (comprising the Medical Director, Director of Nursing and the Chief Executive Officer) for their consideration (Appendix 1). Permission to access the research site was granted pending ethical approval and a nominated gatekeeper was identified. Following ethical approval from the ethics committee of the university and the service area where the study was to be conducted, I then contacted the gatekeeper, the Assistant Director of Nursing (ADON) for the in-patient services, to arrange a meeting to discuss the study and recruitment of participants. However, due to industrial action and the suspension of all non-urgent nursing duties at the time, this meeting could not take place until industrial action was suspended, which was approximately six weeks after making contact.

Recruitment and sampling

Recruitment of participants

When recruiting participants, it is essential to make contact through the approved research processes within the organisation (Burton 2000). Following the gatekeeper's advice, the first stage of the recruitment process involved meeting the nurse manager for each in-patient ward (three in total), informing them about the study and seeking their support. Holloway & Wheeler (2002, p. 40) describe gatekeepers as "the people who have power and control to grant or withhold access to the research setting". All three nurse managers agreed to act as gatekeepers to potential participants in the in-patient unit and agreed to distribute an information package, which included a letter of invitation, an information sheet, a statement of interest form, biographical questionnaire and a consent form to all nurses who met the inclusion criterion on their respective wards, (Appendices 2, 3, 4, 5 & 6). Potential participants were asked to read the information and return the statement of interest

form in the envelope provided, or to contact me either by email or phone, which indicated the respondent's willingness to participate in the study.

Being mindful that nurses might be initially cautious of researchers and fear that it is their practice which is under scrutiny (Roach *et al.* 2009), I endeavoured to mitigate against this by making personal contact with prospective participants as soon as possible and begin the process of building rapport. In order to gain familiarity and as recommended by the respective gatekeepers, I met with as many potential participants as possible both individually and in small groups to present my study. These meetings allowed me to introduce myself, inform prospective participants about the study, explain what participation entailed and answer any questions. Due to the clinical areas' schedules and the nurses' duty roster these meetings took place over a period of 3 weeks. In total, I met with 18 nurses who were employed in the Mental Health Unit. Although time consuming, I found the time spent in the clinical area informative and I learnt a lot from chatting informally with potential participants about the everyday practices of a busy Mental Health in-patient unit. During the meetings, several nurses expressed an interest in the study and commented that the topic area was "*relevant and timely*", particularly since there had been a recent death (four months ago) of a client by suicide in the unit, which had caused much distress for clients and nurses.

The outcome of the meetings with the potential participants resulted in six nurses from two of the clinical areas agreed to participate in the study. I was informed by the nurse manager from the remaining in-patient ward that after some discussion, the nurses had decided not to participate in the study for fear that "*it would re-open difficult feelings about the recent death of the client by suicide*". I thanked the nurse manager and asked her to convey my appreciation to the nurses for their time and interest in considering my research study, and informing me of their decision. However, at the time I was somewhat surprised and disappointed that none of the nurses on this ward had volunteered to participate in the study, particularly given their expressed interest during our meetings. Reflecting on my disappointment and the nurses' refusal to participate I thought about our meetings and wondered whether my enthusiasm to recruit potential participants had led me to mis-read their responses. Interestingly, thinking about the nurses' explanation for refusing to participate in the study triggered the memory of a similar experience I had

encountered over twenty five years ago as a newly qualified psychiatric nurse, whereby three clients had died by suicide within a short period of time, one of whom had died within the hospital grounds. Surprisingly, I had not thought about this incident for many years or the difficult feelings that it evoked for my colleagues and myself at the time. Remembering this incident highlighted the importance of being sensitive to the potential risk of re-stimulating distress or discomfort in those being studied and others, including myself, particularly when undertaking research on an emotionally laden topic such as suicide (Lee 1993, Coyle & Olsen 2005).

Within the hierarchy of an organisation, there may be a number of gatekeepers in various locations and at different stages of the research study (Holloway & Wheeler 2002). Over the course of data collection, access to potential participants was negotiated with several gatekeepers within the services area. These gatekeepers included the Assistant Director of Nursing responsible for community services and two Clinical Nurse Specialists responsible for Home Care; through whom contact was made with nurses working in various clinical settings, including day hospitals, day centres, community psychiatric services and home care teams. Contact with the gatekeepers was initially made by means of a phone call, followed by a meeting, whereby I informed the gatekeeper about the study and explained what was required of participants. Following this, each gate keeper agreed to distribute an information package, which as described earlier comprised a letter of invitation, an information sheet, a statement of interest, a biographical questionnaire and a consent form to all nurses who met the inclusion criterion in the various community-based settings, (Appendices 2, 3, 4, 5 & 6). Potential participants were asked to read the information and return the statement of interest form either in the addressed envelope provided or to contact me by email or phone, which indicated their willingness to participate in the study. Surprisingly, the majority of participants who volunteered to participate in the study chose to forward their names and contact details via the respective gatekeeper rather than contact me directly, which were subsequently forwarded onto me by the gatekeepers. Only two participants contacted me directly when I was in the clinical field to express their interest in participating in the study, while another made contact via email. All potential participants were contacted by phone to arrange a mutually convenient date, time and venue for the interview. In all, thirty three nurses agreed to participate in the study.

Developing the theoretical sample

Theoretical sampling is a central component of a grounded theory study and consists of the selection of different settings or people, or pursuing certain ideas, all of which is a function of developing emerging theories (Becker 1993, Holloway & Wheeler 2002, Breckenbridge & Jones 2009). As a process of data collection, this is where the researcher simultaneously collects, codes and analyses the data, and decides “what data next to collect and where to go for that information” (Glaser 1978, p.36). Theoretical sampling is therefore both “directed by the emerging theory and directs its further emergence” (Glaser 1998, p.157). Since there was no evolving theory to direct data collection at the outset of this study; I began collecting data by purposive sampling and thereafter by using theoretical sampling. Purposive sampling involved the selection of participants or locations based on the research subject using inclusion criterion, which I believed could provide a perspective on the topic being examined (Coyne, 1997, Cutcliffe 2000). At the beginning of the study, it seemed appropriate to talk to nurses working in adult admission wards in a mental health unit. The rationale for this decision was based on the premise that people with mental health problems and at risk of suicidal behavior make up a considerable number of the overall presentations to in-patient mental health units. Therefore, there was an increased likelihood that nurses working in these settings would have experience of caring for people with suicidal behaviour. After initial coding and analysis of data, it became apparent that interviewing nurses working in community settings, in particular, those employed in home care teams and psychiatric day hospitals would add to the development of the emerging theory. Theoretical sampling led to the selection of participants from these community mental health settings. As a result of further data analysis and to add to the development of particular aspects of the theory, nurses who had undertaken further education in different psychotherapeutic approaches and who worked as specialist practitioners in a particular area of expertise, such as, psychoanalytical psychotherapy, cognitive behaviour therapy and dialectical therapy were also interviewed. As the study progressed and concepts began to form, theoretical sampling thereafter focused on the need for more data that was relevant for the emergence of new categories and properties.

Theoretical sampling is not just about sampling people; it also includes modifying data collection procedures, in particular the type of interview questions as the study progresses (Draucker *et al.* 2007) as well as, returning to previously collected data to

look for what Glaser & Strauss (1967, p.72) described as a “sample of categories”. In the early stages of the study, I did not understand the full meaning of theoretical sampling, particularly in terms of its scope or application. As a result, I discovered during discussion with my supervisor that I was unknowingly using theoretical sampling when asking participants more focused questions to sample specific information about emerging concepts. As the study progressed and developed, theoretical sampling guided both the questions I used to collect data and the sources of data to ensure the emergent theory was developed fully. I continued to conduct more theoretically focused interviews relevant to the core category and its related properties, while still allowing for new ideas and concepts to emerge. Theoretical sampling developed and continued throughout the study, until there were no new patterns or possible categories, emerging from the data, which is called “theoretical saturation” (Glaser 1992, p.102). Unlike other sampling methods, it was impossible to know in advance the number of participants required for this study. Glaser (1998) points out that in a grounded theory study there is no such thing as an ideal sample size; instead the sample size is based on saturation. In this study, interviews were conducted with thirty three participants over a period of twenty months.

Profile of study participants

At the time of interviewing, the participants were employed at different grades including: staff nurse (13); clinical nurse manager (12); clinical nurse specialist (5); community mental health nurse (3), and were working in a variety of mental health settings such as; community mental health team (7); home care team (9); day hospital (5); day centre (2); nurse practice development unit (2); admission ward (4) and high dependency unit (4). All participants were registered psychiatric nurses and had an extensive range of professional and academic qualifications at the level of diploma or higher. Several participants held qualifications in mental health nursing (12) and management (2) at post graduate level. Others (12) in addition to nursing qualifications had other qualifications, for example in counselling or psychotherapy, which were both relevant and required for the participants’ particular area of clinical practice. Participants’ length of time working in psychiatric nursing ranged from one year to over twenty years. Almost one third of the participants (10) had undertaken the two day training course on Applied Suicide Intervention Skills Training (ASIST) (see Appendix 7 for course outline). At the time of data collection, five participants, who had completed or were in the process of completing a course in a specific

counselling/psychotherapy approach, attended regular, one-to-one clinical supervision. Another four participants attended a monthly reflective practice group available to staff working in home care. A more detailed account of the participants' biographical profile is provided in Appendix 8.

Data collection method

In this study data was collected initially by using unstructured interviews. The term research interview according to Gubrium & Holstein (2001) refers to any conversation between two people undertaken for the purpose of generating original data for research. As a means of collecting data the interview is a conversation that has a structure and purpose, and whereby the outcome is a co-production of the "conversation partners" - the researcher and participant (Kvale 1996, Rubin & Rubin 2005, p.14). Unlike everyday conversations, research interviews are set up by the researcher to elicit information from the participants. However, Holstein & Gubrium (1997, p.113) assert that the purpose of the interview is more than a "pipeline for transmitting knowledge from informant to interviewer"; it is the discovery of the participants' thoughts, feelings and behaviours. As Fontana & Frey (2005, p.698) state "the focus of interviews is moving to encompass the how's of people's lives.....as well as the traditional what's". Interviews were therefore particularly suited for this inquiry. Furthermore, given the main goal of Grounded Theory research, I set out to conduct interviews with the purpose of identifying the participants' main concern and how they resolve it. Interviewing in research comprises many different formats from the highly structured to the completely unstructured via the semi structured; it can be formal or informal and involve one participant or a group of participants (Holloway & Wheeler 2002, Parahoo 2006). In keeping with the grounded theory design, in this study an unstructured one-to-one in-depth interview was employed at the beginning of data collection, which became in subsequent interviews more theoretically focused on particular issues that emerged throughout the data collection and analysis (Charmaz 2006).

An unstructured, conversationalist style of interview with emergent questions is a specific data collection technique of a Grounded theory study (Glaser 2001). Birks & Mills (2011) recommend that researchers use less structure during the early interviews so that they can follow where the conversation might take them. Listening

to participants' recount their stories is a key feature at the beginning of the research (Glaser & Strauss 1967) and as coding proceeds, categories emerge and theoretical sampling begins, the subsequent interviews become more focused. The use of this method is driven by the generation of theories and is critical to the quality of the theories generated. Furthermore, since stories are social constructs narrated by people in the moment of the interview, neither the interviewee nor the interviewer can predict the course of the interview in advance (Clarke 2006). Therefore, in a grounded theory study it is impossible to predetermine interview questions used for data collection or identify how or when specific questions will be asked before the study begins, since they can only emerge from the data analysis.

The interview setting

The context or the where of research can influence the dynamics, direction and content of the interview (Sin 2003, Anderson *et al.* 2010); it is therefore important that the participant and the researcher feel safe in the interview setting. At the participants' request, all interviews took place in their own work place and at a time convenient to them. Each participant volunteered to take responsibility for booking a room for the interview. For the most part, the chosen venue comprised an 'interview room' normally used for the purpose of therapeutic interviews or meetings, which was comfortable, private and free from interruptions and distractions. On the few occasions when an interview room was unavailable, the interview took place in a large 'activities room' or an office that was unoccupied at the time. Although all the venues chosen were ideal for conversing with participants about their experiences, I initially thought that they might not be suitable for reasons of confidentiality; however the participants did not share my concern and the interviews were conducted as requested in their work place. On a pragmatic level, I thought that the participants, particularly those working in-patient settings chose their workplace as a matter of convenience and for the purpose of maintaining staff cover since being interviewed 'on site' allowed them to be available with minimum delay if needed by their colleagues. However, participants working in various community settings who had more flexible working arrangements also chose to be interviewed in their own work place. During the course of interviewing, I discovered that since the interview concerned issues relating to the participants' clinical practice, they considered it appropriate to talk about such issues in their work place and in work time. Although I never discussed it with the participants, I wondered whether choosing to be

interviewed in their own area of work also provided them with a sense of familiarity, comfort and control prior, during and after the interview. Notwithstanding the above, I appreciated the participants' assistance with organizing the venues for the interviews and the benefits of not having to worry about the logistics of locating rooms suitable for interviewing within the various clinical sites.

Conducting the interviews in the participants' workplace placed me in the position of an 'invited visitor' and allowed me to be privy to their area of clinical practice (Anderson *et al.* 2010). I was aware of my privileged position and appreciated the participants' effort and attention to make me feel welcome throughout the process of data collection. Over the course of interviewing, visiting and meeting participants in their own territory helped me to get a sense of their work environment and feel more attuned to the participants and their area of practice, while at the same time I was constantly mindful not to overstep the boundaries of my position as an invited guest.

Researcher's preparedness for interview

According to Kvale (1996) interviewing is a complex process which should be approached with care and not carried out by inexperienced researchers. Streubert-Speziale & Carpenter (2007, p.37) recommend that researchers engaged in qualitative interviewing should "at least have adequate preparation and understanding of its process, intent and the desired outcome". I believed having psychiatric nursing qualifications, supported by many years as a counsellor and clinical supervisor, together with the support of regular ongoing research and clinical supervision constituted sufficient personal and professional preparedness for undertaking this research. As a novice researcher, I hoped that my knowledge and skills of interviewing, albeit within the therapeutic and supervisory domain could contribute to some degree to the research encounter in this subject area.

Coyle (1998) argues that qualitative inquiry and therapeutic encounters share many similarities. A research interview and a therapeutic or clinical interview both involve the telling and hearing of a unique story, which is distinct, both in its content and narrating (Warne & Mc Andrews 2010). Similarly, the importance of the working alliance and the level of rapport and trust are essential for both qualitative inquiry and therapeutic practice. While in-depth interviewing shares common characteristics with those used in therapeutic practice they are not the same, each is a separate

activity with a different aim. The purpose of unstructured interactive interviews is to gather information about the topic or phenomena being investigated whereas a therapeutic interview is to facilitate change in the person (Kvale 2008). Nevertheless, when conducting research their inter-relationship can often lead to the blurring of boundaries, resulting in the researcher having to tread a sometimes difficult line between interviewer and therapist (Haverkamp 2005, Dickson-Swift *et al* 2006). Researchers must therefore be adequately trained and be clear about the boundaries of the interview process if they are to reduce risk to participants and/or themselves (Drury *et al.* 2007). In practice however, it is not always that easy. While I was aware at the outset that many aspects of in-depth interviewing mirrored significant conditions in the development of the therapeutic alliance, I had not considered the similarities in this study between conducting in-depth interviews with the participants and the alliance between a supervisee and supervisor in clinical supervision until I began interviewing. As a result, I did not anticipate the challenges I encountered when working as a researcher, particularly when the research interview presented situations that might normally elicit a supervisory response. For example, there were occasions during the early interviews when I was uncertain about which role I was undertaking - researcher or clinical supervisor. Listening to the participants and hearing them talk about their clinical experiences and practice including incidents of professional and personal satisfaction and challenge, feelings of fear, sadness and frustration, all of which resonated with my role as a clinical supervisor, as reflected in my journal:

“Did two interviews today, overall I felt they both went well although at times I wasn’t quite sure which hat I was wearing – researcher or clinical supervisor. I felt uncertain and anxious in parts - I think I might have blurred my boundaries when I asked the participant certain questions. I need to think about this a bit more and bring it to my next supervision meeting” (July 20th)

As a result, I sometimes felt uncertain about whether I should probe for more details or to just listen particularly when participants were recollecting and describing challenging and painful clinical experiences, while at the same time I also wanted to provide compassion and support, as well as validate their clinical experiences. Equally, I was also careful not to increase the participants’ feelings of vulnerability and/or turn the interview into a therapeutic or supervisory session. In the early stages of interviewing I questioned my position and whether I was maintaining my primary

role as a researcher. In hindsight, I suspect my initial role confusion and struggle to maintain the interview boundaries was compounded by the fact that for the majority of participants this was the first time they disclosed and discussed specific clinical issues in such depth with another professional, and that only a few participants had access to regular ongoing clinical supervision. Having the opportunity to discuss these challenges with my academic and clinical supervisors helped me to clarify, appraise and manage my role and interventions as a researcher. Over the course of interviewing, I learnt to set aside my curiosity and impulse as a clinical supervisor and hold back my knowledge and skills to facilitate the participants' learning and development about their clinical work. With time and experience, I became increasingly more comfortable and confident in managing the boundaries between my role as a researcher and a supervisor. I also learnt to utilize my skills and knowledge inherent in my clinical practice to enhance the research encounter by establishing rapport and facilitating and supporting the participant to tell his/her story.

The process of conducting the interview

All interviews were carried out by appointment during the participants' working hours and at a time that suited them best. Each interview lasted for approximately ninety minutes. Being mindful of the participants' work commitments and the use of their time, I was careful not to exceed the time agreed at the outset; although several participants stated that they were happy to go beyond the agreed time. Whilst I appreciated their offer, I thought it best to remain within the time boundaries and asked the participants if I could contact them for a second or subsequent interview if I needed to clarify or expand on any issue that may later be significant. All participants gave me permission to return, however, I only returned to one participant as the first interview was terminated abruptly due to an emergency in the clinical area at the time.

As stated earlier, similar to the clinical interview, the process of establishing rapport is an essential component of the research interview. Rapport involves trust and respect for the interviewee and the story he/she shares, which is essential to elicit engagement between the researcher and participant. McLeod (2011) argues that the quality of information obtained depends on the level of rapport and trust between interviewer and interviewee. The participant must trust the researcher before s/he

will feel comfortable to reveal information. Disclosure of sensitive or confidential information is usually only possible once trust has been established between the researcher and the participant (Lee 1993, Knox & Burkard 2009). Bearing in mind that the quality of the relationship between the interviewee and the interviewer can influence the production of data just as much as or more than the questions asked (Marshall & Rosman 1995, Groger, Mayberry & Straker 1999), I strived to establish a relationship with each participant based on mutual respect and genuine interest in his/her perspective. Before starting each interview, I communicated clearly to the participants that ‘I was not looking for ‘right’ answers’ to my questions; instead I wanted to hear their views and experiences. I presented myself in a warm and friendly manner and spent some time in spontaneous ‘social talk’ about various things ranging from the interviewee’s pending holiday, the length of time the person had worked in the particular area, the weather, the catchment area and/or the location of the clinical setting. I also provided the participant with some information about my professional and career background which contributed towards a more open and trusting atmosphere.

Following this, participants were reminded of the voluntary nature of their involvement in the study and the contractual details of their participation were discussed and completed. A brief biographical questionnaire was completed by each participant (Appendix 5). In keeping with the tenets of grounded theory I did not provide the participants with an interview schedule. As each interview progressed, I experienced the research relationship to change from “an instrumental one directed by the research task to a reciprocal and sharing /supportive relationship” (Manderson *et al* 2006, p.1317). Each interview began by asking the participant what Spradley (1979, p.86) called a “grand tour question” or broad open question - ‘what are your experiences of caring for clients with suicidal behaviour?’ This question was designed initially to put the participant at ease and to provide an anchor point for the questions to follow, as well as encourage the participant to “instil the spill” (Glaser 2001, p.175). One of the advantages of starting the interview with an open and broad question was that it provided an opportunity for the participants to talk freely about their concerns (Dickson-Swift *et al* 2006); however, I also recognise that such interactions not only influenced the interviews but were also influenced by the process of interviewing itself (Stevenson 2005). The participants’ concerns generated ideas, which were then picked up by further questioning. Overall, questions were

asked in a conversational manner. Conversational interviewing uses flexibility to determine concepts embedded in participants' reports (Glaser 2001). On occasions the type of questions asked and the way in which I asked them varied both between and within interviews depending on each participant's response to the particular question. As the study progressed, I also became more informed and confident about what questions to ask having become increasingly sensitive through coding, memo-writing and interviewing. Over time and as the categories began to be developed, subsequent interviews comprised specific questions aimed at identifying the properties of the categories, for example 'how do you manage difficult situations?' As such, the emerging concepts determined both the questions I used to collect data and the sources of data to ensure the emergent theory was developed fully. Although I continued to start each interview with an open and broad question, I took on a more directive role in asking specific focussed questions. As a result, different participants were asked different questions as the theory evolved and the interview questions were guided by the emerging theory (Glaser 1992).

Charmaz (2001) points out that for the novice researcher the challenge is to achieve the balance between hearing the participant's story and probing for processes. At times, I found the latter challenging particularly when some participants' stories comprised personal and professional experiences that were emotionally sensitive and challenging for the participant. To avoid being insensitive or disrespectful to the participant, I strived to pay particular attention to how I used probing skills and in particular the timing of my interventions. Bearing in mind Glaser's (1998) advice not to force the data into preconceived categories or close off potential categories too prematurely, I endeavoured not to influence the content of the participants' responses by refraining from asking leading questions or imposing my concerns or preconceived ideas onto the study. Instead I used the skills of paraphrasing or reflecting that is, repeating key words used by the participant, for example '*you said genuine client?...*[emphasis on genuine]. These skills gently signalled the need for further clarification and understanding while staying within the participant's frame of reference (Morrissey & Callaghan 2011).

Viewing the interview as a two-way process which involves the gathering and giving of information, I did not want the interviews to consist merely of a sequence of questions or to use what Booth & Booth (1994, p. 417) refers to as a "hit and run

approach”, particularly given the sensitivity of the topic area. I therefore used various communication skills largely based on the understanding of respect, genuineness and collaboration to facilitate disclosure and the search for mutual understanding. Throughout the interviews, I endeavoured to perfect the skill of what Glaser (2001, p. 172) refers to as an “interested listener” whereby the researcher acknowledges the participant’s participation but without passing judgement on his/her response. This involved listening actively, being alert to interesting leads from the participants and picking up on such leads. Drawing from my clinical skills I also used skills such as open questioning, reflecting and summarizing to pursue these leads and obtain focussed data that informed, extended or refined emerging categories. Rubin & Rubin (2005) calls this responsive interviewing because the researcher is responding to and then asking further questions about what s/he hears from the interviewee rather than relying on predetermined questions. When necessary, I used clarifying remarks such as, ‘can you *say more about...*’; ‘can you *give me an example of..*’ to encourage further elaboration and details, and as a result enhance my understanding of the participants’ stories. My non-verbal communication comprised an open body posture, leaning forward and maintaining appropriate eye contact to demonstrate interest, understanding and empathy. As the interview drew to a close, I asked each participant if there was anything else they wanted to tell me or if there were any questions they may have about the research process and/or study. As part of my reflexivity and ongoing learning and development as a researcher in Grounded theory, I also invited the participants to comment on their involvement in the research process. I asked them for their thoughts about being interviewed and if there were any questions that they thought I should have asked or if they had any suggestions or recommendations for future interviews. Interestingly, several participants reported that the absence of an interview schedule prior to the interview prompted some anxiety about what questions might be asked and whether they could answer them correctly; however they were equally relieved that there was no interview schedule as they feared that they might be ‘tested’ and/or be judged for their knowledge. As one participant stated ‘*if there had been an interview schedule I know I would have felt pressurized to prepare the answers*’ (F12). Additionally, there was general consensus among the participants that being interviewed by a researcher who was a fellow nurse and an outsider to the organization played a significant part in providing a safe, non-judgement space for the participants whereby they could think and talk about what they do in clinical practice.

The interview as an intervention

According to Kvale (1984), the very act of talking with another person that shares a similar interest and is genuinely interested in your viewpoint, and who is not critical can be a very rewarding experience. In this study several participants stated that having the opportunity to talk about their clinical practice had been a positive and worthwhile experience. Several participants were surprised that the time had passed so quickly and that they had contributed more than they had anticipated, phrases such as ‘*I didn’t think I was going to say so much*’ (M8); ‘*Is it finished? the time just flew by*’ (M16), ‘*I can’t believe the time went by so quickly I thought there would be lots of long pauses*’ (F3) were commonly expressed. The relaxed atmosphere and the informality of the interview were identified as significant factors that helped the participants to tell their stories as reflected by the following comments, ‘*I think just sitting down on a one-to-one and not being judged, it was like an informal chat, it definitely helped me to be open about my clinical practice*’ (F7). Comments also suggested that the interviews took on a sense of therapeutic value for some participants. For the participants, being able to talk about specific challenging experiences was in itself beneficial, it not only helped the participants to make some sense of a client’s death by suicide but it also helped them to put the experience into context as illustrated by the following comment:

“The interview it’s been like therapy. I have probably said an awful lot more to you about that incident than I have to a lot of people. It’s good, the client died last November, almost a year ago so I have a little bit of distance from it. The stuff that I talked about, I probably never really thought about it but as we were speaking it just came into my head. It’s been useful having time to process my thoughts about the whole incident. It’s also a relief that I can speak about it without crying my eyes out” (F8).

For some participants this was the first time they had spoken in depth about particular challenging experiences in one sitting as commented by one participant: ‘*I have actually found it [interview] refreshing...it’s the only in depth time I’ve discussed this guy’s death*’ (M13). Having the opportunity to talk about their experiences and hearing themselves describe and explain their actions also provided opportunities for introspection. Some participants indicated that they had begun to think about their practice from a different perspective as illustrated by the following comments: ‘*it’s really made me think about what I do in practice, I hadn’t realised*

that I was bringing my bias into my work with this client” (F14), “it’s [the interview] helped me to understand nurses’ behaviour towards certain client groups. It’s very easy to fall into a certain way of thinking and doing things” (F4). “It’s been good to have time just to talk about suicide; we don’t talk about it enough in practice” (F17).

Tape recording and transcribing the interviews

Glaser (1998) consistently advised against the use of tape recording. He maintained that tape recording was not suitable for grounded theory because it slowed down the process of coding, analyzing and theoretical sampling, as well as restricted the researcher’s creativity and development in doing field notes. He also argued that since the researcher was aiming for conceptual abstraction and not full descriptive coverage, details of every spoken word was unnecessary. In supporting the use of field notes, he recommended that researchers write detailed field notes instead of tape recording interviews, which he considered to be very costly both in time and money. Notwithstanding this, Glaser (1998, p. 111) was aware that tape recording and transcribing interviews were common practice among novice researchers and served to allay their fears of “not getting the data”. Given my invested interest and anxiety in having a complete record of each interview, I decided to tape-record with the participant’s permission and transcribe each interview against Glaser’s (1998) advice. In hindsight, having tangible evidence of each interview reassured me that I was making progress and carrying out data collection and analysis. Also, given my inexperience in taking field notes, I did not trust my ability to recall the interview from memory and feared that I might be at risk of recalling selective components of the interview. Alternatively, taking notes during the interview was not my preferred option as I believed it would interfere with my ability to attend and listen effectively to the interview itself. In order to add to the interview tapes, I also wrote a memo immediately after each interview (see Appendix 9 for examples).

As a novice researcher, recording the interviews was useful for several reasons; it provided me with information about the interview and the opportunity to listen, clarify and review not only what the participant said but also how it was expressed along with other nuances, which might have got lost in the interview itself. Being able to listen to the interview also helped me to appraise how I conducted the interviews, for example my interviewing skills, how I engaged with each participant and my effectiveness as a research interviewer. Reflecting on these issues and

discussing them with my supervisors, I explored ways to make improvements in the way I carried out subsequent interviews. For example, listening to early interviews, I noticed that my questioning skills tended to be overly tentative and almost sounding apologetic. Reflecting on this, I recognized that this was due to my fear of being intrusive and/or leading in my questioning. As the interviews progressed and my anxiety abated, I conducted the interviews with greater conviction and confidence in my judgment and ability. All participants were offered a copy of the transcript on request.

Notwithstanding the benefits of using a tape recorder, I was aware that its presence can have different meanings for different people, be intrusive and hinder participants to disclose sensitive information (Glaser 1998, Warren 2002). While none of the participants commented about the tape recorder or appeared uncomfortable with its presence, it is difficult to determine to what extent tape recording restricted the participants' willingness to disclose sensitive information. However, based on the data disclosed by some participants, it would appear that recording the interviews did not have a prohibitive effect. Ironically, using a digital recorder for the first time I found myself distracted at times during the first few interviews, wondering whether the machine was recording despite having spent considerable time beforehand familiarizing myself with how it operated. Looking back, I now can appreciate that tape recording did result in the collection of large quantities of data which did not substantially add to the theory developed. With my increased confidence and ability, I would now choose to rely on extensive field notes rather than tape recording, albeit not exclusively.

Theoretical saturation

Theoretical saturation the term introduced by Glaser & Strauss (1967) is said to have occurred when no additional data are being found to develop properties of a category, therefore the category has earned its way into the emerging theory. It is the criterion to stop theoretically sampling and is a necessary factor in the integration of the final theory. In grounded theory saturation refers to each of the categories reaching a level of completeness through the constant comparison analysis and the theoretical sampling of future sources of data. Saturation occurs at a number of levels and at different stages of the analytic process. I stopped data collection after the 33rd interview, when the most recent interviews and memos did not seem to make any

substantial contribution to my theory. Although I stopped collecting data I was aware that saturation is always a subjective judgement (Pergert 2009) and therefore always tentative, and to some degree includes what Cutcliffe & McKenna (2002, p.614) refer to as “an element of faith”. I was also aware that my perception of saturation was open to modification through the findings of other researchers or my own subsequent research. As Coyne & Cowley (2006, p.513) summarises “saturation of data may be the ‘best’ that is achieved at that particular time”.

Data analysis: Use of memos, computer technology and mind maps

Memos

Memos, the written notes of my thinking processes were kept from the beginning of data collection and continued throughout the course of this study. I wrote memos at any time or place to capture my ideas as and when they occurred. Ideas emerged at various times, for example when walking, listening to music or watching a play. I also recorded other ideas that occurred during interviewing, transcribing, coding data and when discussing the study and emerging theory with my supervisor, Grounded theory trainees, Barney Glaser and colleagues at The Grounded Theory Institute seminars (see Appendices 10 & 11 for examples of memos). Sometimes these ideas turned out to be of little value because they were non-grounded ideas about the theory (Glaser 1998) that is, they did not apply to other participants or because they were triggered by an external event or issue rather than the actual study. However, there were times when the ideas contributed to important components of the subsequent analysis of data. Over the course of the study, the memos varied in content, coherence, depth and relevance to the finished study. Memos in the early stages of the study were tentative, descriptive and exploratory. Later, with increasing understanding and confidence my memos became more precise, abstract and conceptual and demonstrated the relationship between theoretical categories as well as analyze a single category such as ‘profiling believability’. Memos also varied in length from a few words, sentences to several paragraphs and pages (Appendix 12). In order to prevent ideas from being lost and following Glaser’s (1998) advice I always carried a pen and notebook with me to write my ideas down as soon as they emerged.

Memos were initially handwritten and then typed for ease of retrieval and managing data. Although I found Glaser's (1998) advice to avoid constraining memos and to write without rules and formulations very liberating; at the outset having such freedom was unfamiliar and unnerving, and it took some time before I learnt to trust this 'dictum' and gave myself permission to develop my own style of memoing. Throughout the course of the study, I used memos to record analytic and reflexive insights along with decisions and outcomes of the research process. In addition, memos were used to record my ongoing personal and professional learning and development. Memo writing helped me to stop and think about the data, as well as discover and work with ideas about the emerging theory at that moment. During the act of memo-writing and talking with myself about the data, new ideas and insights emerged while writing. This in turn triggered theoretical questions to check out in subsequent interviews and helped to identify gaps in earlier interviews. I also wrote memos from other memos as the writing and/or reading of one memo prompted further thoughts about the same or a related idea. During the coding and analytic phase, memo writing also helped me to capture and track conceptual ideas about the emerging theory and to develop categories. Memo writing helped me to delineate the code, its properties and to identify how the code fitted into the overall process and integrate other codes; in addition to helping me to make comparisons between data and codes, codes and categories and concepts. Therefore the process of writing more theoretical memos about existing memos enhanced the sorting of the memos and helped to clarify the linkages between the major categories and the core concept. Writing successive memos throughout the course of the study kept me involved in the analysis and helped to increase the level of abstraction of ideas.

Computer technology

The use of computer software programmes to help with organizing and managing data and to assist in the process of coding is common practice in qualitative research (Bong 2002). On commencing the study however, I was advised by fellow Grounded Theory trainees and mentors against their use as they force the data into a linear analysis which is contrary to the principles of Grounded Theory. Glaser (2005) acknowledges that computer sorting will result in a Grounded Theory product; however he argues it will be conceptual description and that "learning to become conceptual and staying creatively conceptual requires hand sorting" (Glaser 2005, p.38). As a novice Grounded theorist and with no prior experience of using data

analysis programmes for qualitative data I did not understand the full meaning of such criticisms at the time, particularly in terms of its application to the analytical process of conceptualization and abstraction. I therefore hoped to learn more about the potential of software programmes by attending training on NVivo, a computer package designed exclusively to assist researchers in the management and analysis of data. Following completion of the training I gained greater understanding about its limited value and decided not to use the software package for the following reasons. Although I considered myself to be relatively computer literate learning to use the programme was an acquired skill that took time, patience and practice. When using the programme I found myself more concerned and frustrated about the logistics of inputting the data at the expense of developing my conceptual creativity. This in turn also hindered my ability to memo quickly and spontaneously and reduced my freedom to move easily between memos on different concepts. Having the opportunity to use the computer programme albeit briefly helped me to better understand “the importance of treating software as an adjunct for analysis rather than an analytical solution in itself” (Birks & Mills 2011, p. 101).

Mind maps

In addition to writing memos, I also used mind maps (Buzan 2006) to illustrate emerging concepts and ideas which over the course of the study resulted in several sheets of large mind maps on the wall. Having a visual representation suited my preferred style of learning (Russell 2006) and allowed me to be creative and play with the ideas and concepts by using coloured pens and post-its. Moving the post-its around the diagram helped me to stop and think about the data, capture creative thoughts on the data, ask questions, discover and work with ideas about the emerging theory as well as provide a record of tentative hypotheses at that particular time. Over the course of the study constructing visual representations together with memo writing helped me to identify possible connections and relationships, as well as show how the categories relate to each other and move from a descriptive to a conceptual level.

Data analysis: Generating the Grounded Theory

In all, data from 33 interviews were coded and analysed. In addition, I simultaneously analysed field notes and memos from informal interviews, and

grounded theory seminars. Consistent with the grounded theory concept “all is data” (Glaser 1998, p. 8) I compared these data with the formal interview data. At the time of developing and employing a demographic questionnaire, I did not understand the full meaning of assuming the relevance of any face sheet variable for example, professional and academic qualifications unless it emerges as relevant (Glaser 1978, 2001). Much of the information that I collected using this questionnaire was of little relevance. Although at times exciting, my experience of data analysis was challenging, circular and fluid. Learning to collect, code, compare and analyse the data, not only required time and effort but also trust in the method.

Open coding

Open coding as described by Glaser (1978, 1998) is the first step of the theoretical analysis and involves taking the data apart. Once the first interview was completed I commenced the process of data analysis by listening to the taped interview and jotting down initial thoughts, reflections and questions. Open coding began by examining the data line by line, a technique recommended by Glaser (1978) in the early stages of analysis and coding for everything possible in the data. The feeling of not knowing fueled my anxiety about missing out on something within the data. While examining the data in such detail in the early stages helped me to become familiar with the data, after coding the first three interviews I began to feel confused and overwhelmed by the proliferation of data produced by the line-line coding. At the time, I was unaware that I was aiming for theoretical coverage and did not fully grasp or trust the premise that if an issue was significant in terms of the theory, it would reappear in subsequent interviews (Glaser 1998). Although I understood the concept of theoretical sampling it took me longer with research experience before I fully grasped the principle that I could always return “to previously collected interviews and theoretically sample them for incidents” (Glaser & Strauss 1967, p.72). Once I began to fully understand the scope and application of theoretical sampling I began to code at a higher conceptual level using a combination of “the language of the participants (in vivo)” (Glaser 1978, p.55) and in “vitro codes (constructs by the researcher)” to reflect the data together with the constant comparison of incidents (Strauss 1987, p.33).

On starting to code, I felt uncertain about the mechanics of coding and questioned which level to code the data – words, sentence or paragraph level. Reassured by my

supervisor and subsequently by Glaser (2008 personal communication) at a seminar, I was informed that the length of the fragment was not important; instead, what mattered was that it was meaningful. At the same time, discussion with my supervisor taught me about coding for the action instead of writing a descriptive level code, for example instead of ‘genuine clients’ I began to code for the action within the incident such as ‘reading genuine behaviour’. Learning to code for action was enormously helpful; it not only allayed some of my concerns about being descriptive rather than conceptual but also helped me to look at the processes and patterns going on in the incidents rather than getting lost in the detail of the content. I recall writing a reflective memo about feeling a great sense of ‘clarity and freedom’ after learning to use gerunds when coding. Looking at each line and allocating codes to words or groups of words, was a challenging and time consuming process. It not only demanded time, a lot of mental effort, patience but also trust in my ability to use the grounded theory method to generate codes. With increasing experience and confidence, I began to fully understand that the process of coding did not happen in isolation but was inextricably linked to all stages of grounded theory analysis and involved a series of overlapping steps that were revised at different stages.

Attending my first Grounded Theory Institute seminar increased my understanding of operationalising grounded theory and my belief in my ability to conceptualize. Being among participants from various professional backgrounds and with varying degrees of knowledge and experience in classic grounded theory was encouraging, stimulating and furthered my learning immensely. In particular, it taught me how learning classic grounded theory requires being open. Although at the time anxiety provoking, I appreciated the encouraging and constructive feedback, and suggestions I received from Barney Glaser and other participants concerning my initial coding ideas. In particular, the feedback helped me to recognize that I had imposed some of my own espoused values and accumulated experience by placing importance on the context of the incidents such as, hospital or community settings, and as a result I had forced the data. Reflecting on this I realized that my anxiety and impatience to manage what Holton (2009, p.43) refers to as the “chaos and control” of grounded theory procedures motivated me to find answers too prematurely and ‘force’ the data. Learning from this, I began to understand more fully that the relevance of context must earn its way into the emergent theory. After the seminar I reviewed, recoded and re-compared incidents, while memoing about the relationships between these

incidents. For Glaser (1998), coding requires patience in order to allow creative insights to emerge. Learning to pace myself and stay with the anxiety and discomfort of ‘not knowing and uncertainty’ did not come easy; it took time, patience, reassurance from my supervisor and self-discipline. Learning to refrain from rushing or forcing the process became an important and ongoing goal throughout the analysis. With time and trust in the principle of emergence, the concept of conceptualizing gradually gained more meaning for me, although my skills needed further development.

Following the cyclical nature of grounded theory, I continued to collect and compare data concurrently, by coding each interview following transcription and developing the categories in greater detail (Glaser 1998, 2001). Over time, I increasingly began to identify when I was conceptualizing and when I was slipping into description. I was also guided by Glaser’s neutral questions when beginning to code the data, such as: “What is this study of? What categories does this incident indicate? What property of what category does this incident indicate” (Glaser 1998, p.123). In keeping with the tenets of grounded theory, I also asked additional questions of the data during coding which emerged from previous ‘open’ coding, for example ‘how does this incident relate to the category of ‘making deals’? Open coding continued until patterns began to emerge from the data, which was followed by selective coding, which involved delimited coding to only those variables that relate to the core category and associated categories (Glaser 1978). This was helped by writing memos and resulted in the generation of more categories and their properties.

During coding, I was very much aware of having experience in the field of suicidology as a mental health nurse, educator, therapist and supervisor. Whilst I aimed to code from a position of openness, I was afraid that my professional and personal knowledge and experience would influence the identification of codes. As suggested by Glaser (1998, p.120), I “interviewed myself”, writing down my experiences and thoughts and coded them, which was very helpful albeit a strange and novel experience. I also utilized my clinical supervision to explore how my education and experience as a mental health nurse, therapist, clinical supervisor and nurse educator shaped my knowledge and practice in the area of suicidology. Identifying what I thought I knew helped me to feel more confident that I was making every conscious effort to suspend my professional concerns.

Identifying the core category

For Glaser (1998) the most pivotal stage of grounded theory is to find the main concern of those being studied that is, the most important and problematic issue for the participants. If a researcher does not conceptualise participants' main concerns, Glaser (2005) believes that it then becomes difficult to discover a core category. However, people are not always aware of their latent pattern of behavior and it therefore takes time for their concerns and the core category to be conceptualized. The core category is the concept that best sums up and explains the essence of what is going on in the data. The conceptualization of the core category does not mean that it simply appeared. The core category emerged through the constant and rigorous process of data fracturing and coding, constant comparison, theoretical sampling, theoretical sensitivity, writing memos, mapping sorting, and processing ideas while at the same time continually asking the questions 'what is ongoing on in the data? what are the participants' main concerns and how do they resolve their concerns?' (Glaser 1998, 2001). In this study, I conceptualised participants' main concern as the desire to protect their own and clients' safety. Although the main concern emerged early in the analysis it was only after interviewing sixteen participants that the core category 'Attenuating Anxieties' emerged. As a core category, 'Attenuating Anxieties' met Glaser's (1998, 2005) criteria of constantly reoccurring in the data and accounting for most of the variation around the concern and best explains how the main concern is continually resolved.

Substantive - selective coding

After identifying the core category, I began selective coding, whereby coding was limited to those variables that relate to the core category and associated categories (Glaser 1978). Together with theoretical sampling, the analysis became more focused and the categories were developed and saturated. I changed the names of some codes to provide a more accurate name, for example the concept 'making no-harm contracts' became 'making deals'. While this stage of coding is presented as a separate process, in practice open and selective coding overlapped. During interviewing I delimited the theory and asked theoretically focused questions about the emerging theory, although contrary to Glaser's (1998) advice, I still continued to allow people an opportunity to talk about their experiences of caring for clients with suicidal behavior. This decision was based on my desire to give people an

opportunity to tell their story in their way and my reluctance to confine interviews solely to asking theoretically focused questions for fear that it would be experienced as disrespectful and disingenuous. For Glaser (1998) collecting familiar incidents does nothing to contribute to the development of a theory; as a result, I prolonged the length of time spent collecting data beyond what was required.

Theoretical coding

Theoretical coding generates meaning and scope to the emergent theory and involves conceptualizing “how the substantive codes may relate to each other as hypotheses to be integrated into a theory” (Glaser 1978, p.55). For the researcher, the main objective is to synthesize emerging categories by creating theoretical links between them, which is called theoretical coding. In keeping with the tenets of grounded theory, a theoretical code must be emergent in the data and not forced onto the data. Once the core category ‘Attenuating Anxieties’ emerged in this study, I began to see the interrelationship between the categories and the core category. It was also clear that my core category was a basic social process and had components of a stage model. Therefore the theoretical codes of process, in combination with causal models and stages emerged as the way to integrate the theory. Cutcliffe (2000, p.1482) believes that theoretical codes function to “provide the full and rich understanding of the social processes and human interactions which are being studied”. To ensure theoretical sensitivity, I purposely did not use social science definitions in order to avoid forcing existing theory onto the emergent concepts. Instead, I used dictionary definitions as suggested by grounded theory methodology, to describe the conceptualized data because they are based in everyday language. Attenuating Anxieties as the core category referred to the process by which nurses lessened their anxieties while working with the person in a suicidal crisis. . It had five subcategories; learning the formula of anxiety, cultivating the anxiety discourse; managing anxieties, containing anxieties and safeguarding against anxieties. These will be elaborated further in the next five chapters.

Ethical considerations

Ethical considerations are paramount in all research studies from its design to the conclusion. Streubert-Speziale & Carpenter (2007) argue that nurse researchers have a professional responsibility to design research that upholds sound ethical principles

and protects the rights and general well-being of their participants. In designing and conducting research it is therefore necessary to give careful consideration to ethical issues at all stages of the research process (Parahoo 2006). However the nature of qualitative research can pose a number of specific issues and dilemmas that require the researcher to remain alert to the possibility of unanticipated ethical dilemmas (Ely *et al* 1991, Shaw 2008). As with all ethical dilemmas there are no absolutes and therefore each situation must be given careful professional judgement to ensure good practice. While professional codes and guidelines provide some guidance and support, they are by no means conclusive or intended to be prescriptive. This study was governed by the principles of beneficence, non-maleficence, fidelity, justice, veracity and confidentiality as described by the International Council for Nurses (2003). The following section highlights some of the challenges involved in applying these principles to the context of this research study and how these issues were managed.

Ethical approval to conduct the study

Research ethics committees have the task of protecting the interest and well-being of all actual or potential participants by examining the ethical soundness of the proposed study and granting approval when appropriate (Parahoo 2006). Ethical approval to conduct this study was sought from the ethics committee of the University and the local research ethics committee of the service where the study was conducted (see Appendices 12 & 13 for letters of approval). A detailed ethics application was completed and submitted to both committees. In keeping with the methodology the data collection method identified in the proposal included an unstructured interview, followed by more focussed interviews as categories emerged (Glaser 2001). Therefore as previously explained in the data collection section, in a grounded theory study it is impossible to predetermine interview questions used for data collection or identify how such questions will be asked before the study begins, since they can only emerge from the data analysis. However, the University research ethics committee requested an interview schedule to be submitted prior to granting approval (Appendix 14 &15). While trying to remain true to the methodology, I compromised to satisfy the ethics review committee and to obtain approval to undertake this study. Following Glaser's advice on such methodological predicaments, I devised a schedule of "general questions to cover [the] area of interest, with explanation on the emergence of interview style and specific questions"

(Glaser 2001, p.141). The ethics application together with the requested sample of interview questions was resubmitted to the ethics review committee. The amended application was reviewed by the chair of the committee and ethical approval was granted to conduct this study.

Informed consent

Informed consent is fundamental to ethically sound research and must always be given serious attention. Grounded in the ethical principle of autonomy, informed consent encompasses the belief that a person is a self-governing agent who has the capacity to think and make reasoned decisions autonomously for themselves (Long 2007). As an essential prerequisite for all research involving identifiable participants, informed consent implies that the prospective participant fully understands the information they are given about the study and what exactly participation will involve (Streubert-Speziale & Carpenter 2007). In order to achieve this, the researcher must do everything possible to ensure that all prospective participants have adequate information about the research, including the potential risks and benefits of participation; their rights not to participate, and are presented with the information without any elements of coercion or persuasion (Parahoo 2006, Royal College of Nursing (RCN) 2011, Ahern 2012). However, given the emergent design of qualitative research in general and of grounded theory in particular, the concept of informed consent is often problematic, since “it implies that the researcher knows before the event, what the event will be and its possible effects” (Eisner 1991, p.214). As stated earlier when applying for ethical approval, I was unable to inform the participants in advance about the type and number of questions to be asked or predict how the interview was likely to unfold in this study. Holloway & Wheeler (2002) argue that the open, unpredictable nature of data collection methods inherent in qualitative research requires a different approach to the traditional fixed, one-off information giving session at the start of the study. In qualitative research, asking for informed consent should be considered as an on-going, fluid and dynamic process that continues throughout the entire study (Lincoln 1990), what Munhall (1988) called process consenting. Furthermore, participants may also have different perceptions about what is ethical or unethical, and therefore constant negotiation and collaboration between the participant and the researcher about ongoing participation is essential (Parahoo 2006). This type of consent, ‘informed process consent’, provides both the researcher and participant the opportunity to continually

renegotiate and revise the original consent as the study emerges and demands review (Moore & Savage 2002, Polit & Beck 2012).

In this study, informed consent was sought at every stage of the data collection process. As stated earlier in the section on negotiating access, all prospective participants were sent written information about the study, which included a letter of invitation, an information sheet, stating the purpose of the study, procedures for collecting data and protecting the participants' identity. My contact details were also provided to allow the participants to contact me at any time during the research process, should they require further information or wish to discuss any issues or questions about the study. Participants were informed at the beginning and throughout the study that they had the right to withdraw from the study at any point, for whatever reason and without obligation or impact to their employment. A minimum of seven days was allocated for participants to decide if they wished to participate in the study. On agreeing to participate, each participant received information about the consent form and all aspects of the study were re-explained. Sufficient time was allocated for the participant to read the consent form, ask any questions and consider whether or not to take part in the study. Participants were also informed that they had the right to decline to answer a question or request to have the tape recorder switched off. Following this, each participant was then asked to sign the consent form, confirming that they were giving their informed consent to participate in the research study, be interviewed and to allow the interview to be tape-recorded. This was then countersigned by the researcher. As previously mentioned, a brief demographic questionnaire was also completed by each participant prior to commencing the interview (Appendix 5). Throughout the collection of data, participants were reminded to ask questions on any issue they had during the interview. Over the course of the interview, participants were offered the opportunity to change or renegotiate the original consent as events occurred, for example, when participants spoke about personal information, I asked the person if she/he wanted the tape recorder to be switched off at that time. None of the participants availed of this option.

Confidentiality and anonymity

Confidentiality and anonymity are important ethical dimensions in a research study. However, the nature of qualitative data collection methods, such as a face-to-face

interview makes anonymity to the researcher impossible (Streubert-Speziale & Carpenter 2007). In the absence of anonymity, ensuring confidentiality procedures were implemented was a primary concern. Confidentiality in a research context refers to “the promise that any information provided by the participants will not be disclosed to others, and will not be reported in a way that identifies the participants” (Polit & Beck 2012, p.162). Several strategies were used to safeguard the anonymity and confidentiality of information given by the participants at varying stages of the research process. At the first opportunity, I anonymised all identifiable data other than consent forms, so that participants and locations could not be identified. Each participant was allocated a code number known only to the researcher. A master list of names and codes was kept separately from the data in a locked cupboard in the researcher’s home to which only the researcher had access. Participants’ details did not appear on the written transcript or in any draft of the report as well as the final report. All computer based data was coded, password protected and only accessible by the researcher. Consent forms, and all hard and electronic copies of raw data, were stored in accordance with the Data Protection Act, (amended) (2003) (Government of Ireland 2003). Discussion of data without identifying individual participants or clinical areas was kept to a minimum, and only with people who had a professional responsibility to maintain confidentiality, including the researcher’s academic and clinical supervisors and a professional colleague, all of whom were professionally bound to uphold confidentiality. A number of interviews (fifteen) were transcribed by a professional who was not involved in the study, had experience in dealing with confidential data and agreed not to disclose any information about the content of the tape recordings. Participants’ personal details were never made known to the transcriber and the content of the interviews was not discussed.

As described earlier, the means by which participants were recruited presented me with an ethical challenge, which concerned the issue of privacy. The majority of participants were recruited through gatekeepers who were nurses employed in various senior clinical positions. As a result, the gatekeepers were privy to certain information, including which nurses received information about the research and since the majority of participants who volunteered forwarded their contact details to the respective gatekeeper; they were also aware of the participants who agreed to participate in the study. Although the gatekeepers were an additional person in the confidentiality loop, they did not know what the participants said during the

interviews. Another ethical challenge that emerged concerned the location of the interviews. As previously stated, since all participants chose to be interviewed in their own work place, they ran the risk of other people knowing the purpose of our meetings. In an attempt to protect their privacy, I informed each participant of this possibility at the outset and gave them time to consider this issue as well as the opportunity to choose an alternative venue. While this caused me some concern, the participants themselves had no problems with their colleagues knowing that they were participating in the study; in fact, several were bemused that I raised it as an issue. This prompted me to question whether my efforts to secure the participants' privacy had unintentionally communicated an element of secrecy surrounding their participation in the study. It also taught me that what is perceived as potentially harmful in a research study may not always be seen in the same way by the researcher and research participants.

As the data collection progressed, several participants informed me that they had discussed their experience of being interviewed with their colleagues, some of whom had also participated in the study. On hearing this, I informed all subsequent participants that they could discuss their involvement in the study with others; however, I would not disclose or discuss their involvement with anybody. Reflecting and talking through the above issues with my supervisors, I learnt how to respond to some of the challenges in which the practice of research ethics presented within the context of this study. In particular, I learnt about the importance of balancing my role and responsibility as a researcher to ensure that the principle of confidentiality and privacy were upheld, while at the same time respecting the participants' right and choice to disclose and discuss their involvement in the study with who ever and whenever.

Similar to clinical practice, serious ethical dilemmas can also arise in maintaining confidentiality in a research study particularly when a participant discloses an instance of unprofessional or potentially unsafe practice. As a researcher, registered nurse, therapist and clinical supervisor, I was well aware of the limits of confidentiality and that in the event of such an incident, I had a duty of care first and foremost to clients and was professionally obliged to disclose such information to an appropriate authority or professional (An Bord Altranais 2002). This information was

stated in the participant information sheet and each participant was advised of this prior to signing the consent form and commencing the interview (Appendix 3).

Protecting participants from harm

In any research study involving human beings, there is potentially some degree of harm. For the researcher, protecting participants from harm that might result from participating in the research must take precedence over the research study, and it is the researcher's responsibility to ensure the well-being of the participants (Williamson 2007). This represents the principle of beneficence and non-maleficence. In qualitative research, one of the unique ethical challenges is the unpredictable and often unstructured nature of the data collection process, such as, individual in-depth interviews (Van den Hoonaard 2002). The potential for harm is inherent in the interview process, which seeks to be fluid and flexible, encourages participants' to tell their stories about a particular topic and often involves sharing personal details and information (Corbin & Morse 2003). Therefore being able to predict accurately the consequences for the participant is generally not desirable or feasible. In this study, the topic area was identified as an emotionally laden subject (Lee 1993) with the potential for arousing powerful and difficult emotions when the participant discussed incidents from practice and/or their own personal lives. In order to protect the participants from harm in this context, I endeavoured to be constantly mindful of the way in which I responded to each participant before, during and after the interview.

Given that neither the participants nor I could predict how the interview might evolve, what might be revealed during the interview, or at what risk, it was essential that I developed a positive relationship with each participant at the outset and be prepared to adapt the interview to the needs of each participant including the need for pacing, taking breaks and/or withdrawal. As described earlier, at the outset of each interview I spent some time in spontaneous 'social talk' about various things. This helped the engagement process by starting a dialogue and diffusing the initial apprehension and awkwardness about being interviewed. I considered this time to be an essential part of establishing rapport and trust with the interviewee as it set the tone and foundation for the forthcoming interview. I engaged with the participants sensitively and respected periods of silence and their readiness to continue with the interview. Following the interviewee's response, a mixture of verbal and non-verbal

prompts, such as ‘*say more*’, head nodding, were used to encourage the participant to share as much information as she/he chose, in their own words and at their own pace. When asking questions, I strived to achieve a balance between allowing sufficient time for the respondent to answer yet not leaving it too long to lapse into an awkward silence and cause the participant to feel embarrassed or uncomfortable.

Some writers suggest that some interviewees may lack confidence that they can answer the researcher’s questions and fear that they will be judged on the quality of their answers (Adler & Adler 2002, Rubin & Rubin 2005). Bearing this in mind and as stated earlier prior to starting each interview I stressed that there was no right or wrong answers and informed each participant that my primary interest concerned hearing their experiences. During the course of interviewing, some participants chose to share personal information relevant to the topic being discussed. In these situations, I listened and acknowledged the disclosure with an empathic and supportive response, for example ‘*you look sad as you talk about the death of your ...*’. I felt privileged that the participants trusted me enough to disclose this information and was mindful not to take advantage of their trust. At the same time, I was also aware that unlike the clinical interview, qualitative research is not a therapeutic encounter and that such personal information was outside the remit of the interview, yet I sensed that some participants wanted to talk about such things. Rather than assume this, I checked with the participant if they were ‘comfortable’ talking about personal matters, and sought their permission to inquire about such issues if it was relevant to the research study and without being intrusive. I was constantly vigilant of the interviewees’ wellbeing and endeavoured to strike the fine balance between respecting the participants’ immediate needs and autonomy while being careful not to be intrusive. For some participants, having the opportunity to talk about such personal and emotional issues, proved to be beneficial, as two participants commented at the end of the interview:

“It’s been good to talk, it’s not an easy subject; I don’t normally talk about [name of person] with my family or colleagues, it’s too difficult for them” (M3).

“I haven’t talked about my brother’s death in many, many years.....my family still don’t accept it” (M17).

For some participants, having the opportunity to reflect on their practice prompted them to share feelings of embarrassment, anger and fear, and appraise themselves and their practice negatively. I was mindful that such disclosures can give rise to feelings of vulnerability which in this study appeared to be exacerbated by the participants' fear about how I might evaluate them as nurses. Comments such as; '*I recognise I can be quite judgemental*'; '*it's not professional saying people are not genuine, you must think I am a terrible nurse*' (F3); '*I feel so frustrated with these clients, I know I shouldn't*' (M2); '*It wasn't a huge anxiety but when I talked about that client, the thought crossed my mind, maybe I shouldn't have said that..I wondered what you were going to think*' (F5), were stated with some trepidation. Being sensitive to their discomfort, I carefully considered my responses, both verbal and non-verbal so that they did not in any way reinforce the participants' discomfort or convey a sense of criticism, yet at the same time I was careful not to dismiss or minimise their disclosures. I listened and responded with understanding and without judgement, while acknowledging and validating their openness and increased awareness about their practice.

Similar to the engaging process at the start of an interview, dis-engaging or ending the interview in a calm and positive atmosphere is an equally important part of the interview (McLeod 2003, King & Horrocks 2010). As the interview drew to a close, I prepared each participant for the ending by forewarning them that the interview was coming to the end. This helped to begin the process of drawing the interview to a close. Being aware that the interview might have stirred up some emotions or discomfort, I allowed time was for the participants to ask questions and/or to give their opinions about their experience of being interviewed. Interestingly, several participants commented that the absence of an interview schedule and the fear of being asked '*unknown questions*' had prompted some anxiety prior to the interview. However, having completed the interview, the participants now appreciated the benefits of having a flexible and unstructured in-depth interview. As one participant commented, '*having no interview schedule or set questions made it more relaxed and informal*' (M5), whereas another participant stated that '*I was relieved there wasn't a list of set questions, if there had been.... I would have felt pressurised to prepare, so that I wouldn't sound silly*' (F11). Before ending the interview, I checked that each participant had my phone number should they wish to contact me at a later date to discuss any issue concerning the interview process. As the interviews involved

exploring a challenging and emotive subject, I ended all interviews by grounding participants back into their reality / world and asking them what they planned to do for the rest of the day or after the interview. After completing each interview, a personal thank you card was posted to each participant acknowledging and thanking the person for his/her time and valuable contribution to the study.

Protecting self and others from harm

While the threat of causing harm or distress in a research study primarily refers to the participants, the capacity for harm can also impact on others, including the researcher (Coyle & Olsen 2005, Bloor *et al.* 2008, Woodby *et al.* 2011). As Lee (1993, p.106) points out “if the interview can be distressing to the respondent, it can also be stressful for the interviewer”. Although I was aware of the participants’ safety in designing and conducting the project; I underestimated the personal emotional demands of conducting the interviews and as a result I omitted to pay enough attention prior to commencing the study as to how I might ensure my own wellbeing while conducting the study. Early in the study, I found that I was physically and emotionally tired after conducting the first few interviews. Although I enjoyed and valued the experience of interviewing; establishing and maintaining good relationships with the participants required a high level of empathic listening, which was both tiring and demanding (Gilbert 2001). Listening attentively to participants and at times to emotionally distressing material provided a cathartic experience for the interviewees, however it was exhausting for me the listener. This was further compounded by my sense of isolation and anxiety in the field area as a novice researcher. Fortunately, I became aware early in the research process that I needed to implement some self-care strategies to manage my own feelings and wellbeing effectively, and furthermore that my ability to engage and conduct subsequent interviews was not hindered or put at risk.

Norcross (2000) argues that good self-care is an ethical imperative for researchers in order to protect both participants and themselves. While conducting the interviews, I used a range of self-care activities as safeguards against potential emotional harm including, utilising my research and clinical supervision as a space to talk through and process my thoughts and feelings, as well as the progress of the study (Davison, 2004, Coyle & Olsen 2005, Dickson-Swift *et al.* 2008). I also used journal writing and gave greater consideration to leaving enough time between interviews when

possible, in order to reduce the intensity of the interview and to process my own thoughts, feelings and responses at the time. These strategies proved to be very useful; they not only helped me to respond in supportive ways to the participants but also helped me to maintain the interview relationship while ensuring that I kept the boundaries between my roles as a researcher, clinician and clinical supervisor.

Given the nature of the subject area and its potential for strong emotional responses, I was aware at the outset that I needed to inform the transcriber about the research topic and that some of the interviews contained material relating to suicide that might be distressing. Following this, I then checked that the transcriber felt comfortable to transcribe the interviews. The transcriber appreciated being forewarned about the interview content and agreed to undertake the position of transcriber.

Summary and conclusion

This chapter focussed on describing how the theoretical and methodological propositions underpinning Glaser's approach to Grounded Theory were operationalised in this research study. The overall aim of the study and a brief description of the research setting were presented, followed by a discussion of the practicalities in relation to access, sampling, data collection and analysing data. Emphasis was placed on outlining the rationale underpinning the decisions made and processes implemented. Throughout the chapter I endeavoured to illustrate some of the ethical, methodological and personal challenges and opportunities I encountered, how they were addressed and the learning I acquired through the experiential process of conducting this research inquiry. Although many of the processes were described in a linear manner, it was through the concurrent use of theoretical sampling, constant comparative analysis, coding, conceptualisation, memoing and sorting memos that the theory 'Attenuating Anxieties' was constructed.

The next chapters six to ten describe the theory of '*Attenuating Anxieties*' and discuss the categories and properties that form the theory.

Chapter Six: Attenuating Anxieties

Introduction

The aim of this chapter is to present the emergent theory '*Attenuating Anxieties*' for this research study. This theory '*Attenuating Anxieties*' describes how mental health nurses responded to clients presenting with suicidal behaviour. A brief discussion of the concepts '*Attenuate*' and '*Anxiety*' as it relates to the core category '*Attenuating Anxieties*' will be provided at the outset. This will be followed by an overview of the complete theory. The latter part of the chapter includes a detailed account of the first subcategory of this theory, which was called '*Learning the Discourse of Anxiety*'.

Attenuating Anxieties: An overview of the theory

Core category

The generation of a grounded theory emerges around a core category (Glaser 1978). For Glaser (1992, 2001) the development of a strong, conceptually abstract core category is at the center of grounded theory analysis. In this study, '*Attenuating Anxieties*' emerged as the core category. The conceptualization of the core category '*Attenuating Anxieties*' emerged as central through the analytic processes of constant comparative analysis, memo writing, theoretical sampling and theoretical sensitivity (Glaser 1998). As a core category, '*Attenuating Anxieties*' reoccurred frequently in the data and explained most of the variation. In addition, it met the criterion of relating meaningful and easily with all other categories and their properties, and had strong explanatory power and grab variables, which Glaser (1978) considers as integral to the generation of a grounded theory. As Glaser (1978, p.93) points out any attempt to develop a grounded theory without a core category will "drift in relevancy and workability".

The concept '*attenuate*' in medicine is not new; it refers to the procedures that weaken, dilute or reduce an agent of disease or pathogen and make it less virulent, yet still keeping it viable or 'live'. An attenuated virus can be administered for prevention, amelioration or treatment of infectious diseases. It can also stimulate an immune response and create immunity, which closely resembles that of a natural infection but does not cause illness. In this study, attenuate is used metaphorically as

a verb and refers to the various reported actions the participants carry out to lessen or reduce their anxieties in order to be able to care for suicidal clients.

In nursing, '*anxiety*' is not a new concept; it refers to a complex emotional process and involves thoughts, physiological reactions and behaviours. Anxiety is aroused when individuals perceive a threat to be real, immediate and demanding an active response. It is a phenomenon that varies in intensity and frequency, and affects both at the level of the individual and collective experience concerning points of uncertainty. Anxiety may be understood as a consequence, which serves the function of alerting the individual to prepare for the imminent threat of danger, real or imagined. In this study, anxiety is used as a noun, in terms of it being the emotional outcome for the participants when caring for clients whose behaviour is perceived as a threat, unsafe and uncertain.

An overview of the core category: main concern and the subcategories

The core category is a dimension of the research problem; it is the category that explains how the main concern of the participants is persistently resolved. The participants' main concerns about caring for suicidal clients were related to their feelings of professional and personal vulnerability and the need to protect both the clients and themselves. When caring for the suicidal person the participants' main concern involved their efforts to keep the client physically safe and themselves professionally safe. Viewing their fates as tied; the participants believed that a client suicide might result in their 'professional death' by being blamed legally and or professionally in terms of fitness to practice by the organisation, profession and society. In addition, as human beings and in most instances having established a working relationship with the suicidal person, they did not wish to bear witness the death of a fellow human being. For the participants, such concerns gave rise to physical mental and emotional anxiety. The participants therefore endeavoured to prevent the client from harming or killing him/herself; by attempting to keep the client safe and alive they also kept themselves safe and 'professionally *alive*' on the nursing register. However, being cognisant of the enormity of their responsibility and the reality that they could not ensure clients' safety they resolved their main concern by attenuating their anxieties throughout the different stages of caring for the suicidal client.

The participants dealt with these concerns through a process conceptualized as '*Attenuating Anxieties*', which had five subcategories, most of which contain a number of related subcategories and properties. These include '*Learning the Discourse of Anxiety*', '*Cultivating the Anxiety Discourse*', '*Managing Anxieties*', '*Containing Anxieties*' and '*Safeguarding Against Anxieties*'. The categories, subcategories and their properties describe the different ways that the participants allayed reduced or weakened their anxieties and at the same time helped to keep clients at risk of suicide and themselves safe. All categories presented are supported with quotations from the interview transcripts and all information that might expose the participants' identities has been removed. The interview number and letter represents the code that was assigned to each participant. Although the thesis is presented in a linear way, the theory '*Attenuating Anxieties*', is not linear, it is cyclical and iterative.

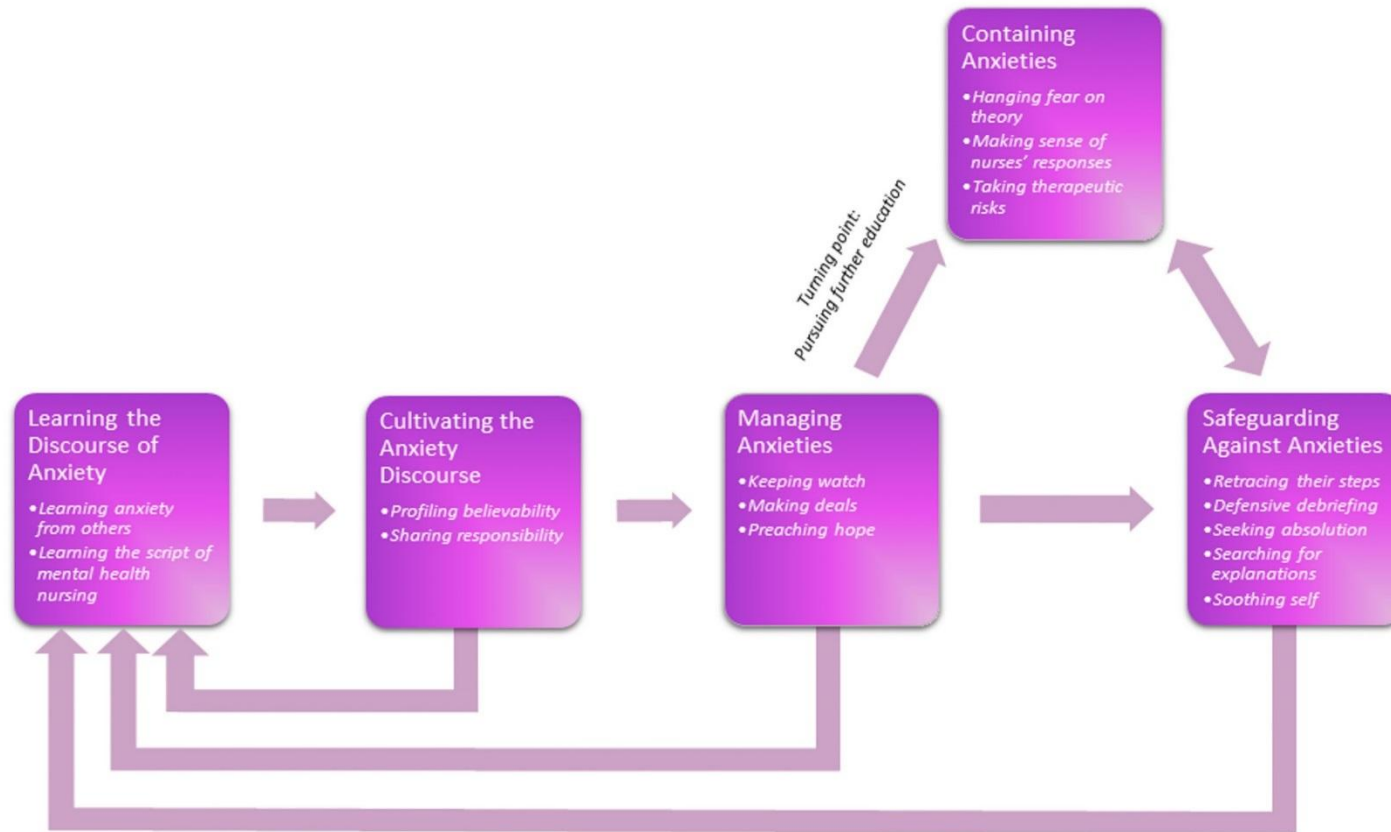
The theory of '*Attenuating Anxieties*' captures the psychosocial process that nurses go through to resolve their main concern, which centres on their anxieties concerning clients at risk of suicide. It is a complex interconnected process that is unique to each individual. '*Attenuating Anxieties*' meets the criteria set by Glaser (1978) of a basic social process in that it contains two or more emergent stages, and is something that occurred over time. The stages can be broken into distinguishing units with their own individual and unique concepts and properties. The stages are in part latent in that they are not readily perceived by the participants. The theory '*Attenuating Anxieties*' also has components of a stage model; however, unlike other process theories wherein the fluidity of movement back and forth between stages is emphasized the participants in my theory do not move back and forth between stages.

The first phase of this theory '*Learning the discourse of anxiety*' forms the bedrock of the theory wherein the participants' learnt to be anxious about caring for a client at risk of suicide. This category focuses on '*learning anxieties from others*' and '*learning the script of mental health nursing*'. After this phase, the participants moved to clinical practice wherein they '*cultivate anxieties*' around caring for a client at risk of suicide. Cultivating anxieties relates to the way the participants conducted a suicide risk assessment and managed the anxieties that it evoked for them concerning the client's physical safety and their professional safety, using the strategies of '*profiling believability*' and '*sharing responsibility*'. The practitioners

implemented a repertoire of strategies to keep the client and themselves safe including *'keeping watch'*; *'making deals'* and *'preaching hope'* and at the same time *'managing their anxieties'*. In the event of a client suicide the participants responded by safeguarding themselves in order to protect themselves both professionally and personally using strategies such as: *'retracing their steps'*, *'defensive debriefing'*, *'seeking absolution'*, *'searching for explanations'* and *'soothing self'*. Some participants recognised the need for further education and skills and went on to undertake further education and attend clinical supervision. For this group, pursuing further education was a significant critical juncture (Glaser 1978, p.100) and resulted in them developing further strategies to keep clients and themselves safe and as a result *'contain anxieties'*, which included *'hanging fear on theory'*, *'making sense of nurses' responses'* and *'taking therapeutic risks'*. While this group also *'safeguarded against anxieties'* in the event of a client suicide however, in contrast to their colleagues they had a place to process their feelings and anxieties, and learn from their experience. Consequently they were able to return to *'containing anxieties'* as opposed to engage in *'managing anxieties'* strategies.

The process of *'Attenuating Anxieties'* as described here is illustrated in Figure 3.

Figure 3. Attenuating Anxieties



Learning the discourse of anxiety

This category refers to the participants' socio-cultural and professional socialisation in relation to suicide. The process of socialisation provided the participants with a particular lens through which they viewed suicide in general and in particular, a lens through which they viewed suicidology in relation to mental health nursing. It will address the different stages wherein the participants learnt about suicide, which are conceptualised as; '*Learning anxiety from others*' and '*Learning the script of mental health nursing*'. While the participants' socialisation occurred over different time periods, they are not separate entities instead they are interconnected through which the participants learnt the rules of communication and behaviours that shaped their understanding around caring for the suicidal person.

'Learning anxiety from others'

All cultures have rules that influence and regulate the behaviours of their society or community. In order to function within a particular culture, people learn these rules and norms through a process of exposure to various discourses. The participants reported their learning related to suicidology was influenced by a number of sources. These included socialisation in the form of family and friends and professional socialisation through their nurse education programmes. Participants spoke of experiencing a societal discourse of suicide that was shrouded in secrecy and shame. The participants also experienced discourse that constructed suicide as an illegal act up until 1993 and contrary to the Catholic Church's teaching of the sanctity of life and as a result the denial of a burial in consecrated grounds. They also learnt that not only was suicide a secretive topic it was also something that brought shame and engendered a sense of shame as described by one participant.

"I think to talk about suicide there's whole stigma attached to it. My friend was around the same age as myself we were brought up in an era where mental illness was not talked about" (M3).

The sense of shame was so intense that even the judiciary system engaged in behaviour that hid the act of suicide as a means of protection for the family of the deceased from the shame and possible legal and socio-cultural consequences.

As reflected by this participant:

“Speaking to a friend of mine whose father was a guard, he said that in the guards when someone committed suicide years ago and whenever they could, the guards would go out and they would maybe cut him down and put him into the bed and he would say he die in his sleep” (M3).

Such practices are supported by early writers on suicide in Ireland (Kelleher 1996) who argued that such practices impacted on the low suicide rates at the time.

The participants, particular those who had personal experience of losing a family member also learnt about the tremendous impact of suicide on those left behind and the trauma of shock, anger, grief:

“My brother died over twenty years ago, I was away but I remember that phone call from my father as if it was yesterday, I couldn’t believe it; I never thought he would do something like that” (M17).

“I’ve had personal experience of suicide, not professional. It was a situation I was actually cross with myself because I didn’t identify it” (F2).

Furthermore, they learnt about the endless searching for answers, as captured by one participant.

“I still can’t understand it, he never mentioned anything. He was happily married, working away, planning for the future. There was no apparent reason...even his family can’t make sense of it” (M3).

In addition, suicide was understood as something that was not to be spoken about both within and outside the family.

“My brother left a note. Over the years I have tried to talk to my parents but they won’t accept it was suicide. They tell everyone his overdose was an accident” (M17).

‘Learning the script of mental health nursing’

On entering mental health nursing, the participants’ anxiety around suicide was heightened. The participants learnt about the importance of protecting suicidal clients and what they had to do as mental health nurses to keep clients and themselves safe. Learning in the classroom occurred through the absence of a dialogue on anxieties

concerning suicide and suicidal behaviour; instead education involved the learning of skills wherein 'doing to' rather than 'being with' was prioritized and skills such as observations, instilling hope, and no-harm contracts became part of the repertoire of responses. Such skills and in particular the use of observations skills were also emphasised as important nursing strategies in key nursing texts and in mental health policies within services as strategies to keep clients safe. Consequently the participants did not have a space wherein they could learn to be able to work with anxiety in a creative way. As Glaser (2009 personal communication) believed coding for absence identified that in the absence of that communicated, creative positive risk-taking skills were not viewed as a priority.

“When somebody comes up and you that they are suicidal , you become quite anxious in that you want to watch them the whole time and make sure that they don't go and act on it” (F4).

“Clients are either sent to a high observation ward or they are placed on a one-one-special – it all depends on the level of suicidal risk” (M4).

The participants learnt that determining the degree of suicide risk required them to identify potential risk suicide factors, which involved distinguishing between suicidal behaviour and self-harm. Although the participants learnt that both behaviours were different, they found it difficult to distinguish the difference since self-harm and suicidal behaviour were often conflated. Furthermore, the lack of knowledge and understanding of the meaning and function of self-harm meant that they did not know how to conduct a suicide risk assessment wherein they could engage in a dialogue with the client about their self-harming behaviour. Instead, the participants focused on the client's behaviour as opposed to learning how exploring with the person his/her distress and as such determine the level of suicide risk for the client at that moment in time. Not knowing with certainty the degree of suicide risk for clients who engaged in self-harm caused nurses to feel anxious and frustrated and as a consequence student nurses also absorbed that anxiety.

“I know self-harm is different it's not as high a risk than someone who is depressed and genuine, but you can never be sure, we had clients here who nearly died, they took tablets as well as cut their wrists. So you have to remember that at times...” (M2).

The ability to engage therapeutically with clients who engaged in self-harm was perceived as requiring advanced interpersonal skills and as such was conducted by other mental health professionals outside of nursing. Consequently, the participants understood that their role primarily involved preventing clients from engaging in self-harming behaviour, yet with little if any understanding of the factors that might exacerbate or help to minimize the client's distress and self-harm.

“The psychologist sees some clients who self-harm or they get referred to the clinical nurse specialist who does psychotherapy” (F8).

The notion of therapeutic risk taking as well as the skills to explore suicidality with the client was conspicuous by its absence from the pre-nursing registration programme. Furthermore, participants were fearful that talking about suicide might be unhelpful and/or exacerbate the client's suicidality.

“Those questions about their mood and if they still feel suicidal would be asked but sometimes I would doubt myself and when somebody you know is not expressing suicide as much as use to , you're less likely to be asking them about – you'd say oh God am I putting into their heads” (F2)

Consequently, the participants did not enter into a dialogic process with clients about their suicidality but instead focused their engagement around issues concerning keeping the client and themselves safe, by identifying the threat of suicide risk, reporting it and implementing the prescribed practice of observation.

“Looking back when I was training, anybody who would have expressed suicidal thoughts was met with huge anxiety and you then got this sudden surveillance the key thing is keep the client safe; it's not much different now” (F6).

The participants learnt by observing others in clinical practice; and listening to discussions of other colleagues about the importance of being vigilant and cautious about what was written in the nursing notes along with the legal and professional 'imperative' to keep people safe. However participants also learnt that client suicide occurred in spite of observations.

Consequently, in the event of client suicide and in order to protect themselves professionally and legally, they needed to provide evidence of what they had done to protect the client.

“You know there’s going to be an inquest after a client suicide and you have to write a report to prove you have done everything within your power to keep them safe”. (F6)

In the event of a client suicide, the participants learnt that a client suicide had far more consequences both personally and professionally than losing a client through death from physical ill health. Witnessing and hearing nursing colleagues’ stories about what happens for staff in the event of a client suicide taught them about the enormity of the distress it evokes and the anxieties concerning responses from family:

“If a client kills themselves, as the nurse you have to live with that for the rest of your career” (M2).

“Even though they didn’t blame me, it was horrible facing them” (M13).

Colleagues also heightened their anxieties concerning client suicide by warning them about the possible organizational and judicial procedures and protocols concerning client suicide. As one participant captured:

“And you see colleagues going through Coroner’s Court. So in one sense you’re fuelled by that but on the other side you have to ask somebody, if you go home tonight are you going to act on these thoughts? You wouldn’t be doing your job as a nurse if you didn’t ask – if I send you home tonight will you act on thoughts that you are going to harm yourself”? (F4).

In clinical practice as in the classroom, conversations or the opportunity to talk about feelings and concerns in the aftermath of client suicide were not encouraged by the organization and nursing colleagues. Furthermore, colleagues advised them that it was in their best interest to keep conversations concerning client suicide to a minimum for fear of being criticized.

As one participant captured:

“Thinking of experiences I had as a student, the whole response to it was to deal with it very quickly and move on. There was a kind of veiled silence around a suicide of a client that was in our care at the time. There was no reflection; it was part of the job so move on now...let’s not go there because it’s safer not to go there” (F6).

Summary and conclusion

The first foundational phase of this theory conceptualized as ‘*Learning the discourse of anxiety*’ refers to how the participants learnt anxieties concerning suicide. Although the participants learnt about anxieties concerning suicide prior to commencing their nurse education, their anxieties were heightened by listening to and observing how nurse colleagues respond to the risk of suicide in clinical practice and by ‘learning the script of mental health nursing’ about the importance of protecting suicidal clients and as mental health nurses what they needed to do to keep clients and themselves professionally and legally safe.

The next chapter will present the chapter of the theory – ‘*Cultivating Anxieties*’.

Chapter Seven: Cultivating the Anxiety Discourse

“Most people who commit suicide talk about it; most people who talk about suicide do not commit it. Which to believe” (Shneidman 1998, p.57).

Introduction

This chapter discusses the second category conceptualised as ‘*Cultivating the anxiety discourse*’. This category describes the way the participants conducted a suicide risk assessment and manage the anxieties that it evoked for them and in so doing cultivated the anxiety discourse that they had learnt during their nurse education and clinical experience. While all participants learnt the discourse of anxiety, the extent to which it underpinned their beliefs, responses and therapeutic engagement with clients presenting with suicidal behaviour varied. This depended on the participants’ education, their belief in themselves and what they could do to keep the client safe together with their reflective ability. The strategies used by the participants are conceptualised as; ‘*Profiling believability*’ and ‘*Sharing responsibility*’.

Profiling believability

‘*Profiling believability*’ refers to ways in which the participants decided the degree of suicide risk for clients. After establishing a relationship with the client, the participants gathered information from the client, their families as well as the client’s notes and work colleagues. The participants asked clients specific questions about their suicidal thoughts and behaviours. They also identified the client’s risk and protective factors as well as categorised clients into two groups based on their clinical judgement of the clients’ behaviours, motives and believability. The two client groups comprised ‘*genuine*’ clients and ‘*attention seeking*’ or ‘*manipulative clients*’. Working in both in-patient and community mental health settings meant the participants were exposed regularly to clients who were considered to be at risk of self-harm and suicide. Consequently, conducting a suicide risk assessment wherein the participants decided the degree of suicide risk for clients was a core activity in their day-to-day practice. The participants needed to decide the degree of suicide risk for clients so that they ‘knew’ what suicide prevention interventions they needed to implement; at the same time, they also required to know how concerned they needed to be to keep the client safe.

As summarised by these participants:

“Caring for someone who might be at risk or have suicidal ideation often entails a lot of risk assessment” (M4).

“Risk assessment that’s a huge part of my job, reducing the risk, putting something in place to reduce the risk either involving the family very much in the care, providing them with other coping strategies for the situations looking at some forms of CBT – their core beliefs and then referral to Acute Mental Health and A & E if the need arises. But it’s all determined by the risk assessment” (M2).

Suicide risk assessments were undertaken by qualified nursing staff with minimal if any, input from other mental health professions. Both experienced and inexperienced participants found conducting a suicide risk assessment a challenging and anxiety-provoking task especially given the unpredictability of human dynamics and behaviours. For some participants, having experience of losing a client by suicide and witnessing the distress and effects for the person’s family as well as themselves and their nursing and medical colleagues further compounded their fears. The participants conducted suicide risk assessments primarily during the initial clinical assessment and at times when the client either alluded or talked directly about their wish to die and/or harm themselves. For many participants, they believed that undertaking a risk assessment was part of the general collection of information during the initial meeting with clients, as described:

“We get a lot referrals to our Day Services from GPs about clients’ with low mood; suicidal ideation, so we would do a suicide risk assessment as part of their overall clinical assessment” (M2).

“In the high observation ward, we do a lot of risk assessments for suicide, especially before they are discharged back to another ward” (F1).

“More people who are suicidal are now looked after at home on homecare. A number of clients that I looked after suffered from depression and sometimes were suicidal; I would assess clients during the daily visits” (M9).

Determining the degree of suicide risk began by collecting information about the client. Ultimately, participants used first-hand accounts from clients when

conducting a suicide risk assessment. However, in some situations wherein the client was uncommunicative or unable to participate in the assessment due to their mental health capacity at the time, the participants then relied on information from a variety of other sources. In such instances, participants gained information from:

“I try to get collateral from the family, the client’s family doctor as well as, collateral history from old charts, prior contact or colleagues” (M2).

Conducting a suicide risk assessment is a relational process wherein one person makes an assessment of another (Reeves 2010). Similar to any therapeutic/relationship, the participants recognised the importance of establishing a relationship with the suicidal client in order to determine the likelihood of suicide risk. This required the participants to be able to connect, engage and communicate with the client who was expressing suicidal thoughts or behaviours. The participants believed that determining the degree of suicide risk required them to talk openly and directly from the outset about suicide with clients. In most situations, they began the suicide risk assessment by asking clients questions directly about suicidal thoughts and behaviours; *“have you ever felt like harming yourself?” (F7)* or *“have you ever had thoughts of suicide?” (M2)*. Many experienced participants perceived themselves to be confident and competent talking about suicide while conducting a risk assessment. They attributed their confidence and ability to the learning they acquired primarily from their increased exposure and experience of working with suicidal clients. The participants recognised that they no longer feared approaching the subject of suicide and were able to ask clients directly and without any hesitation or fear as described:

“I’d say I’d be a 100% comfortable about asking those [suicidal thoughts] questions now. When I first began my nursing training I would have found those questions a little bit awkward because they were new to me. I think because of my lack experience and training at the beginning it was a difficult then but then you have to put the patient’s needs first and your own insecurities behind and ask questions.” (F7).

Notwithstanding the participants’ openness, a suicide risk assessment is dependent on what the client chooses to disclose or keep hidden (Cole-King 2010). Determining the degree of suicide risk is therefore reliant on the person’s disclosure of their suicidal thoughts. The participants had encountered many potentially suicidal clients

who were able and willing to talk openly about their suicidal thoughts, whereas other clients found it difficult and painful. Consequently, they were aware that some clients might not talk about suicide or self-harm directly but instead refer or allude to suicidal thoughts through the use of metaphors or ambiguous statements, as described by participants:

“You sometimes come across clients who might say things like my family wouldn’t miss me if I wasn’t around”; I would now pick up on that and ask the person about suicide thoughts, I didn’t know about this when I qualified” (F4).

“I have known clients who had acute psychosis or acute depression and who had suicidal intent, but they kept it to themselves, they didn’t verbalise it” (M3).

“Some clients would admit that they had thought about suicide.... but obviously sometimes they don’t want you to know that....” (F3)

After determining whether the client had suicidal thoughts the participants also identified risk factors that might increase the likelihood of the client carrying out their intention. At the same time, the participants observed clients’ verbal and non-verbal communication to detect for any inconsistencies between what the client said (or not) and his/her behaviour. The participants utilised such observations as a means of further exploring the suicide risk and determining the degree of suicide risk for the client. In some situations, this confirmed or refuted what the client had said concerning their suicidal intent, as illustrated:

“Instead of just sitting with him for a long period trying to get him to talk I’d go in and out to him quite frequently and let him know that I was here if he wanted to talk. So when he did eventually open up, he said no he was fine and he kept saying I’m fine, - but for my observations skills I could tell that he wasn’t fine and by his behaviour I knew that he still felt suicidal. I knew there was definitely something that was wrong, that he wasn’t telling us. He was masking some of his plans and thoughts” (F3).

“I have met patients who have been genuinely very suicidal who wouldn’t express suicidal ideation verbally, but you would know by their body language or just their presence” (F1.)

The participants used their clinical judgement to determine the client's degree of suicide risk. This involved the participants drawing on what they had learnt formally and informally about suicide risk and protective factors and warning signs. The participants were aware that they needed to ask clients questions about a suicide plan and method of suicide, risk factors such as family history of suicide or mental illness as well as a history of self-harm or attempted suicide. They also identified protective factors about for example supportive family, or employment (O'Connor *et al* 2011). The participants appraised the level of suicide risk by considering each factor in terms of whether it informed the future risk of suicide. Although the participants focussed on established risk factors for suicide at a population level; they also considered the client's individual needs and risk factors when conducting the risk assessment, as illustrated:

"I ask the person various questions when I am doing a risk assessment such as – what's been happening in the last 24 hours and also to speak with the client as well to see what degree of risk they are at the time. Do they have a plan in place to commit suicide? How do you think you would do it? Is there a letter left? Have you tried it before? People with past attempts, it has been shown that people with past attempts of suicide will have a better idea the next time how to do it and will usually succeed. So it depends on the severity of their plan, and the planning of the whole suicide and how much has gone into that, and if again if it's reactive to something in their life. I also ask about their family or what supports that have in their life. This client is unemployed and hasn't got access to his children, that's important for him" (M2).

"We get a lot referrals to our Day Services from GPs about clients' with low mood; suicidal ideation, so we would do a suicide risk assessment as part of their overall clinical assessment" (M2).

"In the high observation ward, we do a lot of risk assessments for suicide, especially before they are discharged back to another ward" (F1).

"More people who are suicidal are now looked after at home on homecare. A number of clients that I looked after suffered from depression and sometimes were suicidal; I would assess clients during the daily visits" (M9).

"I am thinking, my following question might be have they a plan, have they thought about a method, a time to when they are doing it. I think all these questions are key" (F7).

Suicide risk assessment tools were not used by most participants; however, participants working in in-patient units completed the ROVA (Risk of Violence Assessment), which also included an assessment of suicide and self-harm risk. This was part of the unit's risk policy and completed for all clients admitted to the unit. It comprised a list of tick-box questions referring specifically to current and historical risk behaviours as illustrated, "on our admission form there's a section at the end that covers attempted suicide history or DSH it's a tick box" (F3) (Appendix 15). On completion, the participants were required to use their clinical judgement to measure and determine the client's level of risk according to the following categories, "no risk, low, moderate or high risk" (F1).

The participants were anxious to conduct a thorough and comprehensive suicide risk assessment for fear of possible consequences for the client and themselves. They fulfilled this task by placing much emphasis on asking clients "set questions in a routine way have you tried it? Have you a plan in place? Is there a letter? The usual sort of questions"(M4). While asking such questions helped to provide relevant information as part of determining the degree of suicide risk; when asked in a routine way they removed the opportunity for what Reeves (2010, p. 110) calls "risk exploration". Consequently, the participants were not fully aware of how to explore risk by opening a dialogue that might engage with meaning in the context of the client's experience. Neither were they able to discuss with the clients their part in keeping them safe, or the insecurity of taking risks for all involved.

Another strategy used by the participants to determine the degree of suicide risk involved dividing and categorizing clients into two groups, namely: "genuine clients" or "attention-seeking /manipulative clients" as captured:

"There are definitely the two kinds of categories. I personally view self-harming behaviour as something that doesn't have real suicidal intent, whereas real suicidal behaviour would tick more boxes in term of, you know, plan, rescue efforts, you know, um, previous attempts" F11).

The two kinds of clients were those who presented with suicidal behaviour or thoughts, diagnosed ill and judged to be "*genuine clients*" (F1) and consequently believed to be a high suicide risk. The other group consisted of those who presented with self-harm, were diagnosed not ill and who invariably got "under the skin of

professionals' minds" (Johnston 2010, p.232). However, interestingly the participants did not judge them as 'not-genuine'; instead, they used other pejorative terms and labels including: "attention-seeking", "manipulative" and/or being labelled "PDs" (Personality Disorder) (F2).

For the participants, differentiating between suicidal and self-harming behaviours was an essential component of risk assessment practices. The participants viewed suicide predominantly through the bio-medical lens and framed it within the context of 'mental illness'. In particular, they associated suicidal behaviour with affective disorders, substance-use-related disorders and schizophrenia. Alongside the biomedical discourse, they viewed the risk of suicide as a fusion of many other factors such as unemployment, individual demographic characteristics such as gender, age, marital status, together with a wide range of social variables for example, the individual's social support and psychological characteristics including coping mechanisms. Although suicide is a complex and a multi-determined event, the participants constructed suicide predominantly from a pathology perspective. Consequently, they framed suicide as a problem located within the individual with mental-health problems and wherein the distress accompanying suicide was often medicalised as Foucault (1967, p.11) states, "the man of reason delegates the physician to madness". As reflected in these examples:

"I try to understand where is there suicidal thoughts coming from - is it, for example, is part of their depression and maybe there is stress in the background, maybe their family life as well" (M7).

"You have to also be careful and assess for suicide with people who have a diagnosis of schizophrenia or psychosis because you actually don't know what they're thinking - it could be just an impulsive reaction to what is going on. Maybe the voices are telling the person to do it; we had a guy that was like that on the ward a few years ago" (M3).

The biomedical construction of suicide and the suicidal subject, which proposes a cause-and effect relationship, provided the participants with an explanation for the phenomena of suicidal behaviour. When conducting a suicide risk assessment they profiled clients with suicidal behaviour and mental illness as "genuine" and therefore this client group was deemed to present a more serious suicide risk. "I have met patients who have been genuinely and very, very suicidal, they are usually depressed,

hopeless and helpless (F1). This had several important implications for the participants in terms of what suicide prevention strategies they needed to implement to assist these more deserving *legitimate* suicidal clients to choose life rather than death. For the participants, knowing what interventions they needed to carry out with ‘*genuine*’ client also helped to allay their anxieties and provide them with a sense of purpose as mental health nurses. The other client group identified by the participants consisted of clients who self-harm and while these clients may think about suicide, the participants did not believe that they met the criteria for mental illness based on their behaviours and motives. Consequently, they questioned the need for and in fact, some resented that they received hospitalization or medical treatment.

“We have other clients who I think can kind of manipulate suicide, I don’t know how to put this, I don’t want to put it in a bad way, but some people I think find a way manipulating a situation or rotating their care to turn around to the way they want to do it” (F1).

The participants, particularly those working in in-patient settings considered self-harming behaviour as resulting from “*poor coping skills*” (M2) as opposed to what they viewed as a ‘true’ mental illness. Although there are numerous factors associated with repetition of self-harm including demographics; the participants predominantly associated self-harm with female clients who repeatedly used cutting or in some instances overdosing as methods of self-harm:

“I have a lot of people with self-harm actually at the moment on my books, five actually, four of them would be females and aged between 18 to 25” (M2).

Clients who presented with self-harm triggered certain responses, thoughts, feelings assumptions and preconceptions for many participants, which impacted on how they related to people who self-harm. Although the act of self-harming may hold many different meanings for each person who enacts the behaviour (Turp 2003, 2010); the participants’ held albeit unknowingly, a very limited understanding of clients who self-harm. Such understandings and/or a lack of knowledge concerning the reasons underlying self-harm behaviour meant that the participants consciously or unconsciously minimised this client groups’ behaviour, and paid minimal if any attention to exploring and understanding the meaning of functions self-harming behaviour.

“There seems to be a pattern, a lot of these young girls are women who have broken up with their boyfriends, their coping mechanisms seems to be the same, the same thing for all of them, I can’t cope how am I going to cope. And it’s self-harm and sometimes it’s very easy to go down the line and call these people Personality Disorders for a better word. And sometimes it can be very frustrating because what do you do with these people and how do you move them on to the next stage can be very difficult” (M2).

Furthermore, participants found it very frustrating to witness the reoccurrence or threat of self-harm or suicide to gain re-admission within a short period of time very difficult to understand. This was particularly for some participants, as they had invested a lot of time with the client and hoped and believed that the self-harming behaviour would cease. Consequently, the participants felt disappointed and found it difficult not to react in a judgemental, critical or even punitive manner; as captured by these two exemplars:

“You get to know that person very well and you think that you’ve put so much work into them and you kind of get a feeling that you have made some progress with them and then they are discharged and the next week they reappear with same”. So, I am very open and honest and I find, I can be a bit too blunt at times with people and I just say ‘we’ve been through all of this before, what’s different this time’? (F2).

“I just find it very frustrating having put all the effort into seeing them coming back with the same behaviour. I keep going back to somebody who is genuinely depressed, they wouldn't be demanding and intrusive of staffs time. They wouldn't be seeking attention all the time whereas somebody that is repeatedly coming back is completely the opposite very demanding, very intrusive and I want you have to listen to me. If you don't treat me in the way I want to be treated I am going to harm myself. So I find them two very separate groups” (F11).

Against this background of negative attitudes, the participants struggled to work effectively with the complex needs of this client group and managed their frustration by keeping their face to face contact to a minimum and engaging with clients who self-harm only when necessary. Notwithstanding this, although the participants viewed self-harm and suicidal behaviour as different and judged the risk for clients who self-harmed less serious than those with suicidal behaviour; they were also aware that self-harm is strongly associated with completed suicide. In addition, sadly, some participants had known and worked with some people who self-harmed and went on to take their own lives. Therefore, the participants found differentiating

between forms of self-harm and suicidal behaviour was not always clear cut in individual cases.

Nonetheless, the participants were aware that they had a responsibility to keep all clients safe regardless of the presence of mental illness or whether they believed the client's behaviour to be 'genuine', as described:

"Sometimes people can if things aren't going their way or just say like they don't feel they are ready to be discharged ... their plan of care or their treatment isn't going in the right direction that they want it to go. So they're manipulating the situation and say 'Oh I am suicidal' presentation could mean that this person could say 'I am suicidal' and they could be outside and laughing and know having a great time" (F1).

After determining the degree of suicide risk for the client, the participants considered what interventions they needed to implement to keep the client safe and to reduce their degree of anxiety so that they could fulfil their task. These will be discussed in more detail in the next chapter 'managing anxieties'.

Sharing responsibility

'Sharing responsibility' refers to the strategies the participants used to reduce their anxieties while and after conducting a suicide risk assessment. The participants discussed the client's risk with their nursing colleagues after conducting the risk assessment, requested to conduct a suicide risk assessment with a colleague, informed the client's doctor of their concerns and requested another suicide risk assessment to be conducted by the medical team. The participants, particularly those working with clients in their home and community, were aware of the enormity of their suicide risk assessment and the burden and responsibility of their role. Consequently, they decided consciously or unconsciously to share their responsibility by consulting and seeking guidance and support from nursing and medical colleagues about their clinical assessment of suicide risk.

The participants were aware that suicidal behaviour was not a fixed and static position; it was an ongoing process and unique to each client. They were also cognisant of the fact that there was always the possibility of error when determining the degree of suicide risk for a client. Consequently, the participants feared making a clinical decision and "getting it wrong" (M3) and the possible consequences of their clinical decision for the client, their family and themselves.

As reflected by this participant:

“It can be uncomfortable sometimes, If you haven’t made the right decision or not, it’s somebody’s life that you might effect. If you make the wrong call, it’s something that you live with for the rest of your life” (M2).

The participants sought guidance and support from fellow nursing colleagues during the risk assessment process. In most instances, they discussed their clinical assessment and judgement with colleagues by phone during or after conducting the assessment.

“You kind of phoned your colleagues almost, and bounce it off them and they might have given you another question to ask - have you done this, or do you feel happy” (F11).

A few participants occasionally invited a colleague to conduct a joint assessment, particularly if they were very concerned about the client’s potential suicide risk. The participants valued and appreciated having the opportunity to share their clinical decision and concerns with colleagues; it not only helped to reduce their anxieties but it also affirmed their clinical decision and concerns about the client’s safety. In some situations wherein they believed the degree of suicide for the client was high, the participants contacted the medical team and requested for the client to be seen and assessed urgently. However, depending on the outcome of the risk-assessment and whether the client was admitted to hospital or remained at home, the participants still faced the uncertainty of their clinical assessment and judgement.

“As I said the community being 9 to 5 it is very difficult to make the call at 4pm on a Friday afternoon, is that somebody going to be there on a Monday? So that’s what I mean by risk assessment. Does that person need an admission at 4pm on that Friday or do you take the risk and leave them without services after that” (M2).

Summary and conclusion

This chapter discusses the second category conceptualised as ‘*Cultivating the anxiety discourse*’, which refers to the different strategies the participants used to determine the degree of suicide risk for clients. Although the participants conducted suicide risk assessment regularly in clinical practice, they experienced them as challenging and anxiety provoking. While the participants implemented different strategies to help

them determine the degree of suicide risk for clients; differentiating between suicidal and self-harming behaviours was not always easy especially given the unpredictability of human dynamics and behaviours. This further compounded the participants' anxieties and frustrations with clients especially as they were perceived to present with a lesser risk of suicide. Given the enormity of their task to determine the level of suicide, they endeavoured to fulfil it while using different strategies to assist them and allay their anxieties concerning their responsibility.

The next chapter will present the chapter of the theory – '*Managing Anxieties*'.

Chapter Eight: Managing Anxieties

“The most important question to a potentially suicidal person is not an inquiry about family history or laboratory tests of blood or spinal fluid, but ‘where do you hurt? And how can ‘I help you’” (Shneidman 1998, p.6)

Introduction

Following on from the previous chapter, this chapter describes the third category conceptualised as *‘Managing Anxieties’*. This category describes the different strategies the participants used to help keep clients safe, which at the same time helped to manage their own anxieties. While all participants used the various strategies at some point, the intensity to which they practised them varied in frequency and belief in the strategy. This depended on the participants’ education, their belief in themselves and what they could do to keep the client safe as well as their reflective ability. The strategies used by the participants to help keep clients safe and at the same time manage their own anxieties are conceptualised as: *‘Keeping watch’*; *‘Making deals’* and *‘Preaching hope’*. Before moving on to discuss the strategies, an account of the participants’ experience of stress when working with potentially suicidal clients will be presented.

Experiencing the stress of keeping suicidal clients safe

Notwithstanding the importance and necessity of risk assessment, the participants were aware that determining the degree of suicide was only the beginning stage of caring and working with the suicidal person. Working with the suicidal person also involved the application of interventions to prevent suicide. However, only a limited body of evidence-based interventions exists to guide participants in how to work with suicidal people (Maris *et al* 2000). In addition, working with persons with suicidal thoughts, feelings of extreme hopelessness and/or self-harming behaviour meant that all participants experienced a range of intense and extreme emotions. These predominantly included anxiety, sadness, guilt and a sense of responsibility for the suicidal person. In addition, the cost of caring and working with suicidal clients meant that all participants experienced stress and a high level of pervasive anxiety at various times albeit at different levels of intensity and with different clients during their nursing career. This also depended on the participants’ education, clinical experience as well as the extent of their formal and informal support systems.

According to Reeves (2010) newly qualified workers might be more susceptible to such emotional distress as a result of either their age, inexperience and/or the inherent demands of working with a potentially suicidal client. However, for the participants in this study, experience alone did not preclude them from feeling anxious about the client's safety. While all participants used the support of their colleagues to share and discuss informally their clinical work and concerns, few participants had access to regular formal support such as clinical supervision.

While all participants experienced “*worrying about clients after work*” (F5); this was particularly significant for those working in the community and especially participants in assertive home care teams. Working in assertive home care meant that participants often visited clients daily or more frequently if needed during periods of crisis or heightened suicide risk. However, unlike their colleagues working in in-patient settings the participants in home-care experienced stress and anxiety because they were unable to “*hand over the keys, go home and know they had finished their shift*” (F15). Ultimately, they had to trust the client to keep him/herself safe.

“Your anxiety is probably raised more in the community because in the acute units you have a handover. In the community you knock off at 5pm, you don't hand over to anybody as such it's really the family or the person if they live alone” (F4).

Working with this uncertainty caused participants especially those who had prior experience of losing a client by suicide, to feel an unpleasant feeling of suspense when ending their visit and leaving the client alone. They were acutely aware of the possibility that the client might carry out their suicidal thoughts before their next meeting; consequently, they found it difficult to detach themselves emotionally from their work and brought their anxieties home. As participants described:

“It's Friday and you're leaving and although you are physically leaving work, you're mentally still there. You are the last person that sees the patient, you're still going, oh god, I hope this person is ok you wonder will they be there on Monday in the morning” (M10).

“...it’s five o’clock in the evening, and you’re dying to get into work the next morning to make the phone call to see if the person is ok. Which is so unhealthy but it’s always there. I’ve had experiences in the past as well of going home on a Saturday and not being able to contact the client, and the person has actually committed suicide” (F17).

The participants often arrived home preoccupied about a client’s safety and experienced emotional distress and physiological symptoms of anxiety, all of which impacted on their relationships outside of work. Albeit temporary, their anxiety abated when they returned to work and were able to confirm that the client was safe at that time, as described by the participants:

“It’s not very pleasant and I have had more than one sleepless night. It is more the anxiety that you don’t have that peace of mind, for the want of a better way of putting it. You go home in the evening and you don’t know what’s going to happen” (M2).

“I have experienced high levels of anxiety – I couldn’t stop thinking are they still alive, have they done it? Absolutely, it’s horrible, it’s absolutely horrible. It’s like wishing the time away to ensure the client’s ok. The relief when you hear their voice at the end of the line or they answer the door when you call” (F8).

“There were times that I was so worried when I went home and family members would comment that something wasn’t right and they’d say are you OK? (F7.)

Keeping watch

“*Keeping watch*” refers to the different ways the participants observed clients whom they considered to be a risk to themselves because of their behaviours or intended behaviours. As a formal nursing intervention with policies and procedures, the participants implemented ‘observations’, as “the *modus operandi* for providing care to the suicidal client within acute mental health services” (Cutcliffe & Stevenson 2007, p.126). The participants kept clients within their ‘gaze’ by carrying out “*close obs*”, “*one-to-one obs*”, “*specials*”, using close-circuit television (CTTV) monitoring and asking family members to watch clients as well as phoning and visiting clients outside of working hours. Unlike their routine observations, which they undertook as part of their daily nursing activities, the participants viewed ‘special or close

observations' as different in terms of their frequency and the stated proximity to the person being observed. As described:

“Well it’s an open ward so basically we have a check list that is due at 9, 1 and 5 o clock so if somebody is noted not to be around at that time well that’s when we go and do a search. But in general throughout the day you would keep an eye on your patient and see where they are every half an hour to an hour and depending on the risk, you would obviously check in more often with them” (F1).

As a ritualistic practice, the participants implemented enhanced observations in conjunction with other routine nursing practices associated with client safety and after consultation and discussion with the client’s medical team. These included restricting clients’ freedom of movement and *“the removal of sharp objects” (F3)*, which were part of the admission procedure and mandatory for all clients. According to Foucault (1995, p.173) *“the perfect disciplinary apparatus would make it possible for a single gaze to see everything constantly”*. Participants who worked on a locked ward conducted the technique of surveillance by means of close-circuit television (CTTV) situated throughout the ward except for bathrooms. Having a locked environment and a *“higher-staff-patient ratio”* also provided extra safeguards for the participants to keep watch on clients.

The participants implemented continuous observations predominantly to prevent clients from harming themselves. Different levels of observations were implemented at different times according to the seriousness of the assessed threat or risk of self-harm or suicide for the client and in keeping with their workplace’s policy on risk. This in turn, caused the participants to feel anxious about the enormity of their task and more importantly their responsibility to fulfil it. As captured by one participant:

“From a nursing care perspective they wouldn’t be so much ‘oh God he’s a high suicide risk, make sure that you know where is and that kind of thing” (M5).

In most instances, the participants agreed and supported decisions to implement enhanced observations for clients that were considered to be a potential suicide risk.

As described by one participant:

“The observations that you would use for someone with depression and suicidal thoughts or a history of previous suicide attempts, the observations would be much higher” (M5).

However, there were occasions wherein participants disagreed with the medical team’s decision to implement ‘*special*’ observations or to transfer the client to a locked ward for such observations. These disagreements primarily centred around clients who had a history of in-patient admissions and self-harming behaviours, and whom they considered as “*manipulative and attention seeking*” (F2) as opposed to a potential suicide risk. In contrast, the participants believed that this client group warranted a less intensive level of observations, whereby they were observed from a distance. Participants therefore determined the type and level of observations based on the likelihood of different outcomes for clients, that is, suicide or self-harm.

“The category of clients who self-harm would be observed but not directly; you wouldn’t follow them around but if you saw them going off to the toilet, you’d know something is going to happen. You do treat it differently in the sense that you are visualising the outcome as not being the same as the person who has previously made a very serious attempt” (F4).

“You might have a doctor who comes into the equation and decides well this person needs to be on special, this person needs to be in the high observation unit and your assessment of the individual may be in conflict with that and they perhaps don’t necessarily need to be special or moved to the high obs unit” (F2).

Nonetheless, the participants adhered to the medical team’s decision and implemented the prescribed observations, although having to “*special*” clients prompted them to feel angry and frustrated with clients for “*manipulating*” the medical team and getting the close and prolonged “*attention*” vis-à-vis close observations that they sought. However, at the same time the participants were aware that failure to carry out the prescribed observations and the likelihood of an untoward event was at their own peril and therefore they implemented the observations to ensure that clients were “*kept safe and prevented from harming themselves*” (F3).

Despite the limited evidence available to support the efficacy of observations as a means to care for the suicidal person (Cutcliffe & Stevenson 2007); the participants believed that the system of surveillance whereby they “*performed the checks*” (F1)

and recorded their observations was an appropriate and essential means of nursing practice for suicidal clients. Moreover, they believed that such practices secured clients' safety and that they "*don't kill themselves*" (F1). In addition, the practice of observations and belief that "seeing is believing" (Holyoake 2013, p.2) provided the participants valid, tangible and visible evidence (Saeed 2003) of clients' safety and their role in maintaining it. This in turn engendered feelings of safety for the participants, which helped them to manage their anxiety while caring for the suicidal person. It also reinforced the participants' belief that the task of surveillance offers safety from suicide and self-harm as it is purported by the dominant discourse for the care of the suicidal person in in-patient care (Jones *et al* 2010).

"I wouldn't have any qualms about directly observing somebody who has told me they are suicidal like physically being in their eyesight. I would keep it that I am visibly in their eyesight" (F4).

Notwithstanding the need for enhanced observation, the participants experienced the conduct of observation as stressful and reported feeling uncomfortable with "*the intrusiveness of having to follow somebody*" (F2). They also acknowledged the difficulties for clients in terms of having restricted freedom and limited privacy while being observed. Participants preferred the use of technology because the panopticon effect enabled them to observe clients closely from different points yet without the need for close physical contact. They also believed it gave clients a sense of more freedom, albeit within the constraints of being contained within a locked environment. As described illustrated by one participant:

"Yes, observing clients is a lot easier in this ward, the clients they are not actually on special, and it's a higher level of observation. They know that they are being observed anyway, but they're being observed from a distance. It gives them more freedom. So the policy here is that there's always a nurse – watching the screen, they are always in sight" (F3).

Participants who worked with suicidal clients in the community were unable to '*keep watch*' outside of the time designated to their clinical visits, which aroused much anxiety for them, as described earlier in the participants' accounts. Having learnt and cultivated the practice of using observations as a valid means to keep clients safe and alive within the inpatient context; the participants utilised different ways to create the panopticon effect in clients' home in order to reduce their own anxiety. Whenever

possible and with clients' consent, participants engaged family members to partake in maintaining the 'gaze'. During times of concern and anxiety for client safety, participants often asked family members to "*keep an eye on the client*" (M2) as a means of handing the task of keeping watch to the family, which at the same time helped to allay their anxiety and sense of responsibility for the client's safety.

Some participants albeit a few, gave their personal phone number to "*clients at risk of suicide so that they could phone at certain times or if needed*" (M3). This was part of the contract or agreement that the participants made with clients to keep safe, which was also recorded in clients' notes to provide evidence of the interventions implemented.

"The main reason why I would give my phone number that I would feel they would have that direct link with me and likewise I could phone them. Especially within the first couple of weeks until I got to know him, he is over the worst of it he is at a stage now at least he could ring me but I was actually ringing them as well at nine o'clock at night just to see he was ok. One of the ways I dealt with it [anxiety] and it's not everyone's idea in homecare. I gave my phone number to the client and we had phone calls at 11, half 11 at night. It's just there way of just having a little bit of contact with someone. Unfortunately most of the people I dealt with on homecare wouldn't really have much family support" (M3).

A few participants managed their anxiety by enquiring about the client via a colleague whereas others phoned clients outside of their working hours to check clients' safety and allay their anxiety, as described:

"If I am not on at the weekend and somebody else is following them up, I'd ring to ask how is the person is, are they OK, have you been out to see them?" (F8).

"I feel this guy is very spontaneous when he leaves my room, he has to walk cross a river, that thought crosses my head. Is he going to get to the other side of the bridge? So I usually ring him when he gets home? Just to say I'll see you tomorrow or whatever. That's for my reassurance as well" (M2).

Others visited when not on duty and even went to lengths to make an excuse for the visit.

“I’d sometimes just pop in to see the client at the weekend and say that I was in the area, I can then relax knowing that they are okay” “And sometimes, I might go into town on a Saturday shopping or whatever. I might go via that person, just to reassure myself then just pop in. Just say, oh I was passing by, just seeing how you are and all that. Now that’s just to reassure me it’s just because there’s no homecare teams or anything like that at the weekend. I’m doing that of my own I’m really worried about are they going to be alive come Monday 9 am” (M12).

Being able to speak to and in some instances see the client provided them with temporary relief. Participants were aware that they were stepping outside of their professional boundaries, yet they rationalised their decision as a means of primarily assisting the client as well as allaying their own anxiety. For some participants they recognised that over time and with experience they had become more able to detach and reattach with potentially suicidal clients by establishing and regulating their emotional boundaries. Consequently, they considered themselves to be clearer in terms of separating their professional and personal boundaries as participants described:

“I’m getting better at not taking work home with practice and with experience. Initially I would have kept my phone on. But that was in the very early days, and then I thought no, I need to stop this”. (F10).

“Taking things home, that’s something I would have done a lot more of, you know, before. But still, now and again, absolutely, you know, you’d go home having a particular client on your mind” (F15).

“I think my anxiety has definitely reduced. I think you have to somewhat grounded to work in the community because we’re generally working independently. You have to have these safeguards in place for yourself – policies and procedure because situations arise all the time where you’re walking away on Friday evening and questioning, do I worry for the whole weekend?” (M9).

Making deals

‘*Making Deals*’ refers to the agreements made between the participants and suicidal clients about how to keep themselves safe for specified periods of time. The participants made verbal or written agreements under the guises of terms - contracts, promises, assurances, commitments and safety-plans when working with suicidal clients in both in-patient and community settings. As illustrated by the participants:

“Another approach is a contract; they make a promise between you. I’d say to the client - if you have any worries you promise me you’d come to me” (F1).

“I never get into written contracts – it’s not something that I am keen on. I don’t use the word contracts with clients but by me asking the question can you assure menot even promise.....I’ve often used the word assure” (F7).

“When you’re dealing with a suicidal patient, it’s all about, well certainly I would saycan you promise me that you will stay safe until....,” (F12).

“I use a Safety plan from the ASSIST training – I never do that promise thing. I would ask the person can you agree with me that you are going to be safe andif you feel that things are really bad, that you will let someone know” (F10).

Agreements initiated by the participants were not part of any hospital policy or directive; *“...it was never something I was told to do. I put it in place myself” (M2).* Interestingly, other than the ASSIST training programme the participants were unable to identify where they had learnt about the use of no-harm/suicide contracts or agreements. The participants implemented no-harm (suicide) verbal or written agreements in conjunction with other suicide prevention strategies to keep clients safe as well as to contain their own fears while working with the client.

The participants believed that the agreement functioned as a plan of safety wherein clients agreed to carry out specified strategies when they felt distressed or “suicidal” in order to keep themselves safe for an agreed period of time.

“If you are working out a safety plan and that is done collaboratively and, obviously like their involvement is, you know that they have a family with them, that they know who to call, that they can call someone at the weekend or you know that you have all these safety plans in place that is agreed on together” (F15).

Although participants primarily used verbal agreements, whereby they *“took the client at their word” (F12)*, some participants albeit a minority, preferred to use written contracts. Those who preferred written contracts believed that clients who signed the agreement (contract) were more likely to commit themselves and maintain the agreement that is, keep themselves safe; as one participant reported.

“In my experience I would operate very much on a contract. I believe that when people put their name to it – when they sign something 99% of the time they will adhere to it ... my word is my bond” (M10).

Participants also supported the use of agreements as a suicide prevention strategy believing that they contributed to clients having a greater sense of ownership and responsibility for keeping themselves safe. However, the participants were also aware that they reduced their anxieties by replacing the responsibility with the client as described by the participants:

“It’s kind of giving the person more ownership ... a sense of responsibility, and then for yourself there is a certain feeling that you have these structures in place or plans...” (F15)

“There’s a positive effect on the person in that the sense they are saying – no, I won’t do it. I give you my word and that’s their responsibility to keep that” (F4).

While the participants were fully aware that the agreements verbal and written were not legally binding; *“we all know that a contract is not a legal document” (M9)*; they documented details of what the client agreed to do to keep themselves safe in the nursing notes. All written contracts were signed by the nurse and client and a copy was given to clients and kept in their notes. Having tangible evidence of what the client agreed helped to allay the participants’ anxieties by providing them with what they perceived as a *“safety net” (M2)* and evidence of their efforts to keep clients safe. As described by these participants;

“The person has guaranteed their safety until tomorrow and I would document that” (F4).

“When the client promisesit gives you some reassurance to say the patient did commit to me that they would not kill themselves and if they did feel suicidal they would do xx and yy” (F8).

“It’s a sort of safety net for myself to say that this person has signed what they are going to do. They have signed that they are going to stay alive; they are not going to commit suicide” (M2).

When introducing the agreement to clients, the participants often used different coercive strategies to encourage and persuade clients to agree to the plan of safety. These comprised engendering guilt in the client – “*I am taking your word for this - can I trust you that you would do your best to keep yourself safe*” (F7); “*it’s my responsibility to make sure that your safety is priority at the moment*” (F1) or they used the threat of admission to hospital, as captured by these participants:

“I have never used a written contract but a verbal one. Yes I’d say maybe in a paternalistic way if you don’t give me a guarantee I’ll have to have you admitted. Sometimes you do have to be manipulative like that” (F8).

“I have this worry that when you go home tonight you are going to.., we need to do something either you might go into hospital or if you can manage the evening to go home without actually doing something – but I need you to give me your word...” (F4).

Unsurprisingly, few clients refused directly to agree to the safety plan. However, participants acknowledged that if and when clients did not feel able or have the capacity to give their consent and told them that “*no I can’t give you that promise*” (F7); they would then explore other options with the person concerning their safety.

Participants believed that for clients to be able to disclose reasons for their refusal to consent, it was essential to have a well-established therapeutic alliance with the client as described by the following participants:

“I think it comes back to your therapeutic relationship and getting to know the person and if you have a good therapeutic relationship with them, you can talk to the person, they will tell you if they can’t guarantee not harming themselves” (F4).

“Most people are very genuine if they say yes to something, I have never experienced a client refusing but if they did say no my alarm bells would be ringing and I’d be saying right we need more here then” (F12).

A few participants recognised the infallibility of no-harm contracts especially given the “*changing human dynamic of the suicidal person*” (Reeves 2014 personal communication), which might influence clients’ capacity to adhere or not to the agreement. Therefore, while participants’ anxiety abated temporarily with the use of

such agreements, it was never eliminated while working with the suicidal client, as described by these participants:

“It does allay your anxiety....when you’re going home. I suppose in one sense you’re thinking, they have given me their word’ that.... I can document that exactly; I can go home, knowing that if the worst comes to the worst. But you have in the back of your mind that somebody can say that to you, but, if they go home and they’re feeling low that may not necessarily be the thing that keeps them alive that night. So you never can relax, there’s always the risk” (F4).

“I suppose you’re never a 100% certain when you’re walking out the door” (F7).

Preaching hope

“*Preaching hope*” refers to way the participants utilised the concept of hope as a therapeutic intervention with clients considered to be a suicide risk. The participants explained the meaning of hope, helped clients to identify reasons for living, reminded clients of their reasons to life and stressed their importance as well as focused on positive things within the client’s life. As a recent phenomenon in mental health nursing the participants endeavoured to instil hope when working with suicidal clients to help keep clients stay safe. The participants viewed hope “as *part of instilling hope*” (M8) and were aware of the potential therapeutic value of hope as a suicide prevention strategy. They believed that increasing clients’ hopefulness and reasons for living helped to reduce the risk of suicide for clients. As described:

“That’s the biggest thing for me as a nurse whenever I work with somebody who is suicidal. To try and find whatever it is that that person has in their life in terms of hope” (F4).

However, given the dearth of literature and research to guide or inform the participants how to inspire hope in suicidal clients (Cutcliffe & Barker 2002); they struggled to define the concept of hope and what it actually entailed as an intervention. While they recognised that hope meant different things to different people (Schrank *et al* 2012); they searched for definitions that could help them describe and understand this complex and nebulous phenomenon and intervention. As part of their efforts to explain the meaning of hope to clients they used metaphors commonly associated with the concept of hope; however, these also proved

inadequate and instead it reiterated the idea that what constituted hope was unique to each person. As captured by one participant:

“It’s very difficult sometimes what I see as hope and what I see as light at the end of the tunnel is not necessarily what somebody’s else sees. Light at the end of the tunnel for somebody might mean just to die, to be finished with all this. So I don’t know” (M2).

Notwithstanding such challenges, the participants conceptualized *instilling hope* in suicidal clients as an intervention wherein they helped clients to “*identify what their hopes were*” (F4) and then used such these as an incentive to help them recognize “*why they should stay safe and alive*” (F4). In most instances, clients identified something or someone that was important or significant in their life, also referred to in the literature as ‘protective factors’ (Kutcher & Chehil 2007, p.6). Participants believed that instilling hope also meant focusing on the positives in the client’s life, as if in some way this could remove or dissipate the clients’ hopelessness. In fact, the participants did not consider it beneficial to discuss the clients’ lack of hope or feelings of hopelessness for fear that it might exacerbate their sense of hopelessness and potential risk of suicide.

As one participant stated:

“You dwell on the positives and ‘well if your family is there, there’s support for you’ – that’s the starting point. I definitely think if you dwell on negative you’re obviously going to be more negative. If they could just see a glimpse of light and see that if they have positive things in their life, keep working on those things, eventually will be a breakthrough” (F1).

Participants were aware that some clients because of their personal circumstances found it very difficult to find reasons to live; consequently they struggled to instill hope with these clients. Nonetheless, they worked hard to find something for the client, no matter how small or temporary “*to help clients hang onto something*” (F2) so that it might deter or prevent them from harming themselves. As described by the participants:

“You try to find what it is for that person that you can latch onto for that person, whether it is they might have children, their partner, their mother, brother or whatever it might be. With a view to trying to get them to see that’s why you should want to live, that’s what you have to look to when

you're feeling so low at night and you're thinking there is nothing - I want to kill myself" (F4).

"Sometimes you will come up across somebody who seemingly has very little to live for and they tell you all this and you say this is pretty horrible, it is a horrible existence that you have got at the moment but it's a matter of trying to get them to look forward but that's how things are now, but it may not necessarily always be that way. It doesn't have to be always that way (M5).

Working with suicidal clients, participants frequently encountered situations wherein clients were suffering from a lack of hope. The participants often felt emotionally burdened and a sense of helplessness talking to suicidal clients who lacked hope; consequently they found it difficult to sit and listen to their feelings of hopelessness and negativity. At the same time, they were also aware and concerned that feelings of hopelessness were significant risk factors not only of mental health disorders in general, but particularly in depression and suicidal behaviours (Beck 1963, 1974, 1986). Feeling emotionally burdened by the clients' hopelessness and anxious to prevent the client from harming themselves, they reacted with a sense of urgency by attempting to "*instil hope in the clients*" (M2).

The participants believed that this would help clients to find renewed hope and interest in their lives and consequently reduce their suicide risk, as described:

"It's very hard to deal with someone who is feeling hopeless. It can weigh you down, it can definitely weigh you down if you are having a one to one with a patient on a regular basis and everything is negative and everything is horrible and dreadful. I found that very, very difficult because it felt like you were going nowhere" (F3).

"It's draining because we all like to mix with happy people, sociable people. And I think people who are suicidal tend to be a lot more depressive, probably a lot harder to engage with as well" (M6).

"You pull out all the positives you can because I think if someone is in that frame of mind, feeling that low, feeling that depressed where they are contemplating suicide then from an internal view they don't see any positive way out. You start to try and get positives for them. So you have to try and find a way where they can see the positives" (M5).

Suicidal people clearly need hope during times of stress; however, as Cutcliffe & Barker (2002, p.617) argue suicidal clients cannot be “forced to become more hopeful; forced to feel less suicidal” Instead, the process of hope inspiration needs to be subtle, unobtrusive and implicit rather than explicit (Cutcliffe & Grant 2001). The participants however, adopted a directive approach wherein they worked hard trying to convince clients that they had someone or something to choose life rather than death. In addition, some participants used emotionally coercive strategies to persuade clients to refrain from harming themselves by engendering guilt in the client, as illustrated:

“I would ask the client - if you do commit suicide – what happens to the people that you leave behind?”(F4).

“I try to talk to them and say – you’re loved ones, you don’t own yourself, you’re not alone, whatever your problem is - why not share it with close relatives. You put them in a very bad situation if you do this kind of thing, they love you so much without making them feel guilty” (M4).

“As the key worker - you build up the relationship you might get to know over the years when they talk about Johnnie, whom they love and couldn’t live without or whatever. So you remind them of that...” (F2).

Some participants justified their use of instilling hope based on clients’ positive feedback, which further validated its contribution to supporting suicidal clients’ recovery. As captured by one participant:

“And a lot of the time the person usually comes back to you and says I do feel that I have that now, that you have shown me that little thing to focus on” (M3).

The participants as “mental health nurses were ideally placed to be one such source of hope” (Cutcliffe & Barker 2002, p.617) and inspire hope in the context of their supportive relationships with clients. Although the participants constantly acknowledged the importance of the therapeutic relationship when working with the suicidal client; interestingly they did not identify or consider its importance and potential role as a means of inspiring hope. Furthermore, they did not consider how listening and exploring clients’ feelings of hopelessness could paradoxically act as a means of instilling hope by conveying to clients an important caring and helping

practice. Instead, the participants constructed instilling hope as a stand-alone intervention that was applied in response to clients who were articulating a lack of hope or feelings of hopelessness, and to allay their feelings of discomfort and anxiety.

Participants who did not engage in interventions

A few participants did not engage in implementing the above strategies when working with suicidal clients. These participants had undertaken further training in different psychotherapeutic approaches and attended regular clinical supervision. While they were aware of the interventions and acknowledged that they had probably used them prior to their psychotherapeutic training, they were quite sceptical and critical of their therapeutic value for the clients. They also questioned whether their colleagues ‘made deals’, ‘preached hope’ or ‘kept watch’ were more for their own benefit and self-protection rather than the client and wondered if they were aware of how these interventions might impact on suicidal clients.

As captured by this participant:

“I don’t use any contracts, Home Care staff use them like I am going to be visiting you again tomorrow and I ask that you give me a commitment that you will stay safe. I am sure I probably done it myself back in the day. But it depends on each client and the situation; it wouldn’t be something I personally would use. I do think they are more about the anxiety of the staff than they are about the welfare of the patient because at the end of the day if a patient is going to do something my asking them to make a promise to me unless I have a good relationship with them and even at that – why would I keep a promise to someone that I haven’t met before. There’s huge omnipotence in it really” (F5).

In addition, they also disliked the way instilling hope was being used routinely in a way that minimised clients’ distress and discouraged in-depth discussion and exploration of their feelings and meaning. They believed that as with all therapeutic interventions, inspiring hope as a therapeutic intervention required much thought concerning its timing, the underlying intention and whether it was an appropriate or effective intervention for all depressed or suicidal clients. As reflected by these two participants:

“Hope...it’s part of that instilling hope thing. You hear ...everything will be grand, you know, you’re just a bit down at the moment, things will be grand, once you get out of here” (M7).

“I think that there’s probably a time and a place for that and I don’t think everyone’s going to respond to that. I think they may do eventually but a lot of the time if you’ve got somebody who’s just coming in, they’re severely depressed or even quite depressed or severely distressed a lot of the time that’s not going to work I think that should be left for later on”(M8).

“So if I say I just feel awful at the minute and I’d just like to go out and take all my tablets and die, and the nurse says you have a good family, husband. I’d think she isn’t listening to me. She is not listening to what I am saying, I want to be dead, and I don’t want to live anymore thank you very much. I want her to know that I want to be dead. I know I have got a husband and a family and that they’d be devastated if I was found dead tomorrow morning. I know that I don’t need the nurse to tell me that I want the nurse you to listen to me” (F5).

Notwithstanding this, the participants acknowledge that working with suicidal clients was stressful and anxiety provoking,

Summary and conclusion

This chapter presented the various interventions implemented by the participants aimed predominantly to prevent clients from harming themselves. This in turn, helped them to manage their anxieties concerning the client’s well-being and safety as well as demonstrated their professional contribution and effort to prevent client suicide. However, despite their efforts they had learnt from personal experience and/or colleagues that the prevention discourse failed to incorporate the many uncertainties of human experience. Participants were therefore aware of the risk of uncertainty and unpredictability when working with suicidal clients. Consequently, they were unable to predict the likelihood of suicide and prevent clients from carrying out their suicidal intentions. Being acutely aware of such issues challenged participants’ sense of professional omnipotence and triggered their concerns about accusations from the organisation, colleagues and the client’s family of being irresponsible and held responsible. Such beliefs heightened participants’ anxiety about working with the risk of potential client suicide. In the absence of a culture, which fostered a continuous attitude of enquiry and valued the importance of having a safe and supportive space to share and discuss the complexities of the task,

participants consciously and unconsciously used interventions, which were defensive in nature and served as a means of self-protection against possible blame and as a way to manage their ongoing anxiety when working with suicidal clients.

The next chapter will present the penultimate chapter of the theory '*Containing Anxieties*'.

Chapter Nine: Containing Anxieties

“Containment – the capacity to manage the intense disturbing interactions involved in the care of patients, to withstand pressure to act precipitately, to maintain the capacity to think” (Bell 2014, p. 1)

Introduction

This chapter is about a small number of participants who also learnt the anxiety discourse, cultivated it and managed anxieties, before proceeding to undertake further training in different psychotherapeutic models. This penultimate chapter conceptualised how they contain their anxieties as well as enhance their confidence and competence to work with suicidal clients. It will address the strategies used and conceptualised as; ‘*Hanging fear on theory*’, ‘*Making sense of nurses’ responses*’ and ‘*Taking therapeutic risks*’. Before discussing the above strategies and to provide context an outline of the participants’ experience of pursuing further education in a psychotherapeutic model will be provided.

Turning point: Pursuing further education in a psychotherapeutic model

The turning point that moved participants from managing anxieties to containing anxieties was a decision to undertake post qualification training in a psychotherapeutic model of their choice. Having trained and worked as mental health nurses, the participants recognised that they lacked the knowledge, skills and confidence to work with clients in a more advanced and therapeutic way. Consequently, they felt unskilled, unsure and dissatisfied with their clinical work at different times during their nursing career.

They recognised that their primary nurse education was insufficient and limited in preparing and assisting them to work beyond the dominant biomedical discourse and cultures of “prevention and cure” (Reeves 2010 p.50), as described by these participants.

“I suppose it wasn’t just per chance that I did CBT training. I remember when I trained as a psychiatric nurse in the 1980s.....at the end of the training I said well what more can I offer? What more can I offer than a good neighbour or a good friend with the level of knowledge I have. I was trained as a psychiatric nurse, but it wasn’t that I thought I hadn’t got skills or I hadn’t got knowledge because training at that time was very black and

white ...it was about the signs and symptoms of depression...schizophrenia and so on, but what's next, what do you do with it? How do you help people? I didn't feel you got much understanding about how do you help people" (M1).

"When I was working on the units, managing patients who were self-harming and patients who were suicidal – it was mainly about specializing. Often there would be medication involved as well but the combination of the two or just giving medication wasn't enough. Being able to sit down with clients and work through whatever was going on with them at that time did seem to, how can I put it; take the heat out of the crisis. That's what led me to think about doing further training" (F5).

Wanting to be able to work in a more psychologically orientated way and to work more therapeutically and effectively with clients, including those who presented with suicidal or self-harming behaviour motivated the participants to undertake training in a psychotherapeutic model, as captured by one participant:

"There was a girl; she was 16 or 17 when I first met her in my last job, I had a good relationship with her for about 3 years. She self-harmed and was diagnosed with BPD and for a long time we didn't have a psychologist, psychotherapy was the way forward with her. She had about 6 months with a psychologist, then the psychologist left and she wasn't replaced. I felt helpless I wanted to do something with this client rather than just labelling her. So, I think there was a sense of wanting to do something positive for these people that led me to start my course in CBT" (M9).

For these participants, engaging in a training of psychoanalytic psychotherapy, cognitive behaviour therapy or dialectical behaviour therapy, "...implied the notion of training and professionalism as well as the sense that therapies are conducted according to a model that guides the therapist's actions" (Roth & Fonagy 2005, p.5). A central component in the process of their psychotherapeutic training meant that the participants were required to attend clinical supervision on a regular basis; in addition, some participants continued their supervision post training as a recommended or required contributory element of their continuing professional development (CPD) (Nursing Council Nursing & Midwifery (NCNM) 2003). Clinical supervision was conducted by professionals allied to mental health that worked outside of the participants' immediate work setting but were familiar with and experienced in the participants' chosen psychotherapeutic training, as described:

"I get supervision from a psychologist who is very experienced in CBT" (M9).

“Part of the agreement for taking this job was that I would get regular supervision....we discussed it at my interview; I wouldn't have taken the job without it. As they hadn't got anyone experienced in the Psychoanalytic model, they agreed that I could find someone outside and they would pay for it” (F5).

For those participants who had completed their psychotherapeutic training, the development of senior, clinical nursing positions in community mental health (NCNM 2008 a & b) presented them with the opportunity to take up such posts and work as autonomous practitioners using a specific psychotherapeutic model as clinical nurse specialists and advanced nurse practitioners. This meant that the participants took referrals from other disciplines to work with clients with specific issues and to work using a particular psychotherapeutic model. As ‘specialist’ practitioners, they utilised their advanced knowledge and skills in the provision of short or long-term counselling /psychotherapy for people with serious and complex mental health needs, including those presenting with suicidal and self-harming behaviour, as described:

“I work in long term psychotherapy with clients, so a lot of them would have interpersonal difficulties, personality difficulties and so death wish and suicidal ideation comes up not all the time but quite a lot. Some of them would have a history of perhaps suicidal intent and they would have a history of overdosing and sometimes cutting” (F5).

“On my case load, there are a few people I suppose with whom suicidality is a constant and there's a family history of suicide completion as well” (F9).

Having a supportive thinking space

Unlike other participants, this group of participants had access to regular clinical supervision, which provided them with a designated, supportive thinking space, wherein they could reflect and discuss their fears and concerns about their clinical work. This space is critical in helping them to contain their anxiety in a way that enabled therapeutic engagement to take place. Clinical supervision serves a dual purpose; to promote and protect the welfare of the client and the development of the supervisee (Carroll 1996) or as Barker (1992, p.66) asserts “to protect people in care from nurses and to protect nurses from themselves”. This dualistic role incorporates the functions of clinical supervision – educating, supporting and monitoring the supervisee’s clinical role (Hawkins & Shohet 2007). The participants valued having

a safe, supportive, thinking space, wherein they could seek guidance and direction concerning their clinical work as well as process the emotional impact of their work, particularly when anxious about their work with suicidal clients. As participants stated:

“Most of the time I go to CBT supervision looking for direction” (M9).

“To sit back and to think about clients that demands something else of me as a nurse; it also demands things like reflective practice and clinical supervision” (F9).

According to Seager (2008, p.217) “there is a qualitative difference for the client being cared for by a carer who is contained than one who is not”. For some participants, in the event of a suicide or a serious attempt, additional supervision was especially important in helping the participants to safely reflect on their practice in a non-judging way and to consider the rationale for any decisions with respect to the client as well as to help keep their emotions contained, as reflected by the following participants.

“There are so many blind spots when you’re working with someone who is severely borderline and I don’t think I had enough supervision at the time; she did commit quite a dramatic act of self-harm. She is alive today now, she survived it. I am not working with her anymore that was probably the most difficult time for me professionally. I certainly feel I need a lot of supervision when working with someone like that” (F5).

“I often discuss the issue of suicide in supervision if issues came up in therapy; that issue would definitely be one I’d discuss. I have had two clients who have died by suicide in my care. At the time, I felt like I have failed them, even though I wasn’t the only person involved. I felt very uncomfortable and I discussed it a lot in supervision. It’s not comfortable and it was an issue for me to try to deal with - I’d like to think that maybe we can learn from what didn’t work that time and although I know we can’t save everybody - I understand that as a fact but yet I’d like to think that we can do something in another way” (M1).

Hanging fear onto theory

“Hanging fear onto theory” refers to the way the participants metaphorically hung their anxieties concerning their clinical work with suicidal people onto their psychotherapeutic model of practice. In this highly emotional context, the

participants were aware that working with clients who were suicidal or expressing self-harming behaviour meant being exposed to intense and extreme emotions, including feelings of anxiety, both for the client and themselves.

“As I said earlier, there’s always a sense of worry and concern that the person might do it. I think it’s working with uncertainty, the main emotion it brings up is worry and I think your theory as well as policies and procedures, they may not take it away but they reduce it somewhat” (M 9).

Notwithstanding their worry, the participants believed that having a psychotherapeutic framework equipped them to work more effectively and competently with potentially suicidal clients as well as the clinical issues that the clients presented. Their new found theoretical framework also provided them with concepts, principles and values, which guided and informed their clinical decision making, interventions and relationships with clients. This in turn, sustained their professional role and identity as competent and caring professionals and at the same time helped contain their anxieties. In this way, their psychotherapeutic model of practice served a dual function, as outlined by the following participants.

“We all need something to hold onto. I hold onto my psychotherapy training and understanding and hopefully from what I know of that theory that’s what I hold onto. Experience also counts for a lot. I am a long time in nursing and it’s certainly a few years now since training in psychotherapy and I feel I have a long way to go” (F5).

“My DBT training ...it gives me confidence about what I’m doing” (F9).

“I think my anxiety has definitely reduced, if I hadn’t done this CBT course I probably wouldn’t be as informed as I am, it has probably forced me to go and investigate how I work with clients” (M9).

“DBT gives me good insights into how other members of the MDT work as well as all of the knowledge the actual skills itself are beneficial itself in every day practice. But also it gave me a very good insight into the actual behaviour, the suicidal behaviour, what’s behind it. It was good to just give me a better understanding as to what the client was actually going through” (F17).

Working from a particular psychotherapeutic lens also provided the participants with another language or discourse (Briggs 2010), which helped them to develop a deeper

understanding of the possible meanings of clients' behaviours and distress. This also helped the participants to develop a greater capacity to be more empathetic and compassionate particularly when working with clients who presented with significant risks for suicide and self-harming behaviour and who were often associated with the diagnosis or label of Borderline Personality Disorder.

“When I was nursing/training, Personality Disorders were not part of the curriculum, it wasn't mentioned. I actually didn't know what it meant and it's only in more recent years through psychotherapy training that I have actually become to understand it and I think that's one part of feeling more skilled” (F5).

“I think my CBT course has made me look into situations a little bit deeper. It's about conceptualising things, looking at things in earlier development, how problems are contained, maintained and all that. I suppose stopping and thinking before you make a judgement about somebody. Looking at somebody a little deeper, people with PD have had very traumatic childhood or history of sexual abuse I suppose to put it in very simple terms, it's not surprising that they, Personality Disorder the person develops an idea about themselves this kind of very much drives everything they do” (M9).

“There's an attitude towards clients, who are seen as personality disorder. I know they are a difficult group, but there is a valid reason why their lives are very, very difficult” (F9).

Having a therapeutic framework outside of nursing enabled the participants to articulate their competencies to safely and effectively practice a range of psychological interventions. For the participants, this legitimised and validated their therapeutic role and input, as reflected by one participant:

“It's about working in a way to remain skilful in how the client negotiates their stress or their emotions. That's the piece that links to DBT training, the stress tolerance and emotional regulation, interpersonal skills, and trying to keep things in the moment, the mindfulness part of it. So, that particular training has helped me then to maybe get directly into a focus with the person” (F9).

Notwithstanding the different emphasis and application of the various therapeutic models used; all participants considered the relationship between the client and practitioner as paramount, which is in keeping with all psychotherapeutic orientations (Roth & Fonagy 2005) as well as the discourse of mental health nursing

(Peplau 1952). In fact, Barker & Buchannan-Barker (2008) argue that the therapeutic relationship is the most important variable in the success of clinical work, as these participants illustrated:

“I think in terms of people with Personality Disorder most of this illness is driven by very deep rooted cognitive processes, schemas or core beliefs. Psychotherapy has been proven to being successful with this client group but it takes time. I think a lot of the value with this client group is the therapeutic engagement and actually being there with somebody and being consistent even though a lot of the interventions that you try don't work or fall short. You have to put a lot of value into the therapeutic relationship” (M9).

“The people I am working with they are not passing through, they are sitting here for a while and there is a relationship. I give a commitment to the relationship so I'm there for all the different bits and the way that I work everything is important from the time I see the patient in the waiting room until I see them walk down the stairs so that's the whole session. So everything about how they come in, how they wait, greet me and everything has meaning, whether it's about bringing the children to school or whether they want to be dead. It's all part of the session and it all part of that that gives meaning and its parts that link and understand and that's the way I think about it. It's not just the crisis I am responding to – all part of the therapeutic relationship” (F5).

Briggs (2008a, p.219) argues that “psychological containment is less about containment in buildings and institutions than about containment in relationships and social networks although both may be important”. Similar to the therapeutic alliance, the knowledge and skills that make up the therapeutic dialogue are also essential aspects of helping the person who is experiencing mental health problems or emotional distress (Morrissey & Callaghan 2011). Cutcliffe & Stevenson (2007) argue that engaging therapeutically with the suicidal person requires the practitioner to be able to listen to the person's distress as well as help him/her to talk about and explore the meaning of their suicidal thoughts and self-harming behaviours. Feeling more grounded by their psychotherapeutic training and practice, coupled with clinical supervision, the participants recognised that they now responded more therapeutically and effectively when engaging with clients who were potentially suicidal. They now considered themselves to be more able and skilled to listen and facilitate clients to talk about their suicidal or self-harming thoughts and behaviours. In relation to suicidal behaviour, including self-harm they recognised that “it is not so much the nature of the act that counts but its meaning” (Chasseguet-Smirgel

1990, p.77). Furthermore, they also considered themselves to be better able to ‘be with’ and contain the client’s psychological pain and negative emotions, described as “psyche ache” by Shneidman (2001, p.201), rather than be distracted by their own anxieties about working with the potential risk of suicide, as outlined by two participants.

“Before my training....I wouldn’t have had the repertoire of skills to look at the distress and try to understand it and to talk about it, what’s going on with the distress and even stay with it. It’s ok to stay with that awful distress at that moment, as a practitioner I would now stay with the person in that distress for the moment before I then move it to another little bit” (F9).

“I suppose in the way that I work now when people are bringing ideas of being dead and ideas of wanting to harm themselves and sometimes it can be impulsive ideas that they might have of wanting to harm themselves. I look at it more from the point of to provide a space where they can actually say those things because I think it can be very difficult to say those things” (F5).

Reflecting on their clinical practice prior to their psychotherapeutic training, the participants considered how they responded to potentially suicidal clients; unknowingly, they avoided engaging in meaningful emotional contact and interventions and instead reacted by ‘doing’ something or suggesting things for the client to do, such as ‘making deals’ and ‘preaching hope’. At the time, the participants believed that their interventions were intended to fulfil their professional responsibility to ensure the clients’ well-being and safety, and to allay their own fears that the client might carry out their thoughts of self-harm or suicide. Thinking about how they practised, the participants were aware that their responses to clients were driven by fear and their need to protect their professional self. They also acknowledged how such responses might have inadvertently silenced the clients by not utilising the opportunity to listen and explore in-depth the person’s potential for suicide or self-harm, as reflected by the two participants.

“When I think of it, I would visit someone and say sure, let me get up and make you a cup of tea, or suggest why don’t you do this....I would just leap in. At the time, I suppose, trying to be helpful and wanting to be useful” (F9).

“I look back on my time on the wards and I think, perhaps I was defending myself rather than being able to think about what actually the person was

saying to me. I do think that sometimes patients can perceive it as this, that they are being pushed away. If I was a client and the nurse said I could do this or that, I'd think she isn't listening to me. She is not listening to what I am saying, I want to be dead, and I don't want to live anymore thank you very much. I want her to know that I want to be dead. That's a skill for the nurse to be able to allow yourself to hear somebody say that and actually take it in, contain it, think about it and actually offer something back that has meaning; it helps them to know that they have been heard and that I can be heard by somebody and they will know how awful I feel" (F5).

Making sense of nurses' responses

“*Making sense of nurses' responses*” refers to the ways the participants explained how they responded to clients who present with repeated suicide attempts or acts of self-harming prior to their psychotherapy training and their nurse colleagues' responses. While the participants did not compare or consider themselves to be more-or-less skilled or competent than their colleagues; they were able to critique themselves and others. The participants were aware of the negative attitudes among some nurses working in-patient psychiatric services towards clients who were admitted for repeated self-harming behaviours and suicide attempts, as reported in the nursing literature (McHale & Felton 2010). The participants viewed such attitudes to be unhelpful to both the process of advancing therapeutic engagement and promoting safe and positive mental health, as participants stated:

“There is negativity about this client group and it's very widespread; you just kind of fall into it” (M9).

“I suppose it seems to be the opinion out there that; but I do find actually, that a lot of people would think that, that nurses might not have the same amount of empathy for some people or for people who, who repeatedly self-harm. And, you know, there is an opinion that, they would be seen as time wasters” (F17).

“I just think that a lot of people's attitudes towards that client group are unhelpful – it doesn't help the communication with the person. They are people who spend a lot of the time in our service. I think if we could work with them and understand them and understand what they are coming to us because I think they are communicating something to me, it's resonating in me and I think to be able to use that communication helps to develop the relationship”. (F5)

Given that people who are at risk of serious self-harm are often admitted to in-patient psychiatric services (Bowers 2005); the participants believed that it was important

for nurses to have a greater understanding of the meaning of clients' self-harming behaviours, so that they could develop a more positive attitude and therapeutic relationship. While the participants acknowledged that their nurse colleagues invested much time and energy with this client group at the outset; they observed that they became increasingly disappointed, frustrated and resentful when they did not see that they were making a difference and the clients continued to be re-admitted for self-harming or suicidal behaviour. As participants described:

“It’s that piece about fault because if I give all of myself, all of my professional knowledge, all of my time, giving of yourself and you’re not coming up with the goods that’s your fault, it’s not mine I’ve given you everything so the fault lies with the patient” (F5).

“They tend to get admitted fairly regularly, and realistically why people are angry about that I don’t really know but there’s a sense they are offered things and they are given things and generally they just don’t want to engage. They just want to do what they do” (M9).

The participants believed that nurses responded by attributing the ‘blame’ onto the client rather than reflecting on their responses and identifying what interpersonal issues might be going on between them as part of the therapeutic relationship. According to the participants, this occurred because unlike other clients with a diagnosis of mental illness, nurses profiled this client group to have the capacity of choice and self-control concerning their self-harming behaviour. The participants believed that holding such beliefs contributed to the development of negative attitudes and a sense of hopelessness directed towards this client group, often resulting in the withdrawal or reduction of therapeutic engagement with the client, as outlined by this participant:

“The person who self-harms gets blamed whereas the client with schizophrenia or you has chronic depression or bipolar, well God love you that’s something that’s happened to you, it’s not your fault. It’s just something that wired or not wired in your brain and that’s why you have these symptoms” (F5).

The participants acknowledged that working with this client group presented personal and professional demands, particularly concerning their unpredictable behaviour. Consequently, this often evoked fear for nurses, especially concerning

the potential risk of suicide. Nonetheless, they believed that nurses needed to be more aware from the outset of the nature of working with people with mental health problems including those who presented with suicidal behaviour, and the inherent professional and personal rewards and demands that it presents. As the participants stated:

“The reasons why people make judgements about Personality Disorder because sometimes that behaviour can be very difficult. Every so often people with Personality Disorder can be manipulative or play games which can be difficult for people to deal with at times. Again emotions like fear are very prevalent. Impulsive behaviour is a common characteristic of Personality Disorder” (M9).

“I also think if you are going to work with people that just having a knowledge of what the condition is - is not enough because they are actually making demands on you as a person and I don't know when people come into the job and give the commitment to the job within psychiatry and within general, but more so within psychiatry I don't think that it's actually said to them that this is a kind of a job that actually makes personal demands on you as well. You are actually giving of yourself as well as doing things” (F5).

Furthermore, taking a systemic approach to understand their own and colleagues' behaviours, the participants being aware of the deficits of their own nurse education, also believed that the lack of education and designated support systems also played a significant part in contributing to nurses' negative attitudes and unhelpful and defensive responses. As participants described:

“I don't think that there is a lot written within nursing I am talking about standard nursing training that actually helps people to understand what their condition is. I think staff don't have that bit of training to help them understand what actually might be stopping that person from being integrated into the world. And I think with more reflection perhaps supervision they could look how they are being drawn to the client, that in itself is a warning sign I am feeling drawn to this person” (F9).

Taking positive risks

Taking positive risks, refers to the ways this group of participants weighed up the potential benefits and risks involved when working in the community with people who presented with the risk of suicide or self-harm. In line with current mental health policy ‘A Vision for Change’ (DoH&C 2006), the participants strived to support individuals with mental illness/health problems in the community by promoting a

community-based mental health service and a philosophy of recovery. With the advancement of community-based mental health care and specialist services, together with the more recent trend towards earlier discharge from psychiatric inpatient units (DoH&C 2006), the participants were required to manage more than ever the risk of those who receive their services. According to Beck (1999, p.135) risk is “*always culturally constituted and as such is always imbued with culturally determined values*”. In keeping with suicide prevention policy ‘Reach out - National Strategy for Action on Suicide Prevention’ (HSE *et al* 2005), safety and promoting positive mental health was central to the participants’ professional practice. Assessment and management of risk was therefore an integral part of their everyday practice, as summarised by one participant:

“In the past, clients would have been in hospital for much longer ... having Home Care Teams and CPNs means, clients don’t go into hospital unless it’s really necessary and they are discharged much quicker now, it has its advantages and disadvantages” (M9).

Guided by policies and procedures responsive to risk, the participants recognised the importance of minimizing the risk of suicide and self-harm to protect the welfare of clients, the community, as well as their own self-protection. However, in contrast to views commonly held in mental health practice and to the other participants in this study, this group understood and defined working with risk differently in that they did not consider risk to be inherently negative. Similar to Morgan’s (2000, 2004) perspective of positive risk taking, they believed that risk also had a positive component and that managing risk should not focus solely on its elimination. The participants viewed positive risk taking as an important way of working with clients to reach their potential benefits, while at the same time reducing the likelihood of harm occurring as a result of taking risks (Titterton 2005), which also fitted with the recovery approach to mental health services. Implicit in this understanding of therapeutic risk taking is the idea that “*risk and uncertainty are closely connected*” (Eriksson & Hummelvoll 2012, p. 593). Therefore this meant that the participants were aware that risk assessment and management involved a professional duty of care, wherein the person’s needs and well-being were balanced with issues of personal and public safety, as reflected by this participant.

“I think that’s probably the most difficult question ...it would probably be one of my nightmares to end up in court having to defend myself because

court works differently to therapy or any type of psychiatry, it's all black and white. As you are aware therapeutic relationships are not black and white. If I am in black and white I can't function, it's keeping myself out of the black and white is my struggle sometimes and practice as safely as I can" (F5).

Despite the dearth of professional literature promoting positive risk taking (Titterton 1999, Stickley & Felton 2006), the participants adopted a therapeutic risk-taking approach over a 'safety-first' or 'defensive practice' in their work with clients (Titterton 2005, p.13, Manuel & Crowe 2014). Determining the level of suicide risk is reliant on the person's disclosure of their suicidal thoughts, therefore, risk assessment requires the person to confess any thoughts that may signify risk. However, as Cole-King (2010) points out without this disclosure the clinician can only make their judgement based on observation. Beck (1999) points out that risk assessment is an institutionalised attempt to control the actions of individuals. Knowing that some clients had experience of institutional detainment; the participants were sensitive to the dilemma that some clients faced concerning whether to disclose their suicidal thoughts for fear of the consequences of such a disclosure. At the same time and depending on what the client disclosed, the participants were also aware of the decision that they might face in terms of whether to refer the client for a psychiatric assessment and the possibility of the client being admitted to hospital with or without his/her consent. When clients disclosed thoughts of suicide or self-harm, the participants worked positively and constructively with the client and did not respond out of fear or react by taking over or directing the client; but instead they listened attentively and facilitated the client to talk about their suicidal thoughts in greater depth. For this group of participants, therapeutic risk taking entailed identifying the potential risks and developing plans and actions collaboratively with the client that reflected their positive potentials, stated risks and priorities at that time. This process of risk assessment involved evaluating the riskiness of the client's thoughts and actions. However, as Webb (2012, p.138) argues risk evaluation can only measure "*propensity of future events, but not actually predict future events*", although at times it appears that this is what is often being demanded of practitioners. Reeves (2010) argues that risk assessment or risk exploration is about making an informed judgement wherever possible in collaboration with the client about the likelihood of an event happening, given all the available information. The participants weighed up the potential benefits and risks involved for clients individually, while drawing on their knowledge of the client and

the nature of the therapeutic relationship, and at the same time, underpinning their decision with an understanding of their psychotherapeutic work undertaken to date with the client. As one participant described:

“I was stirred up, now I took a risk with that lady, now I know her very well, I didn’t know what the outcome might be that night but I thought then what could I do, she was going to the Out Patient Clinic the next day. She doesn’t want to take medication. I did talk to her about how she might use the OPC and about looking for something that might help her to sleep. I did that kind of practical piece with her. Well if I get a doctor in to see her now, she is not going to accept medication, she is not wanting to go into hospital. Going into hospital isn’t going to make any difference to her. She could come out and do the very same thing. And I felt where things might change for her might being in therapy and I took a risk. I knew she has family living very closely and I know her husband [not personally] that he was aware of her risk and would not have left her” (F5).

Considering each client and his/her situation individually; the participants’ judgement was also informed by their knowledge and understanding of what had worked or not worked in the past for the client and for what reasons. In collaboration, the participants also identified the client’s particular attributes, characteristics or behaviours that were regarded as signs of potential risk factors and protectors during that specified time. Similar to participants who managed anxieties, they also did not use risk assessment tools; in fact, some participants questioned whether their value and whether they hindered the process of therapeutic engagement and argued that they were sometimes used for the protection of the organisation and not necessarily the interests of the client (Beck 1999).

“Risk assessment tools ... I am not sitting in front of a patient with a piece of paper and go tick, tick, tick. I don’t see the benefit of it and it doesn’t help me or the client. Obviously if I have to do it I will do it, but hopefully I won’t (F17).

“My anxiety around nurses using these is I think they can be a defence and they can put a distance between them and the patient. It’s about asking lots of questions which could get in the way of having a conversation. I think that sometimes the Risk Assessment tool is more about allaying the anxiety of the nurse than it is about actually helping the patient to work with their suicidal ideation. And I know everybody is defensive about their practice to whatever degree and some more than others and nobody wants to be the person standing up in court” (F5).

Having undertaken the assessment of suicide risk with the client, the participants decided upon the therapeutic interventions that aimed to reduce, contain, or ameliorate the risk for the client. Although the participants considered their interventions to be the best options available for the client at that time; they were aware of the dynamic nature of risk and therefore its unpredictability. Nonetheless, the participants' considered their positive risk taking as defensible for the individual client at a particular time, while being mindful of the anxiety that it stirred in them they were not controlled by that anxiety. As summarised by one participant:

"I'd like to think that any risks I have taken in my career have been educated and informed risks. I am not sure I feel that it's been always in the patients best interests to be a 100% sure that the patient is safe because I don't think it's possible. Sometimes patients do things impulsively and can you lock up somebody and deprive them of their liberty in case that they might. And hopefully it never happens but if I do end up in court I will stand on my judgement or fall on that, my experience and my judgement. I can't know always if I am making the right decision but I hope have to be able to walk away from my decision and feel that was what I felt to be the right thing to do at the time but obviously I could be proved wrong by further events. I can never quite know that, I can only feel I have done my best" (F5).

According to Johnson (2010, p.245) "*therapeutic risk taking cannot be contained if the professional does not feel contained*". The participants' psychotherapeutic knowledge and clinical experience together with access to clinical supervision all contributed to feeling more contained that is, they felt held emotionally and psychologically. Consequently, they felt more skilled and confident in their clinical thinking processes so that they knew when and how to take positive risks in order to work more effectively with potentially suicidal clients.

Summary and conclusion

This penultimate chapter of the theory described a small number of participants who moved from a position of 'managing anxieties' to 'containing anxieties' while working with clients at risk of suicide. Acquiring further education and clinical experience in a chosen psychotherapeutic approach helped the participants to underpin their clinical work with a different theoretical model, which provided them with a different way of understanding and working with suicidal clients. This experience, along with the provision of clinical supervision enabled them to have a safe thinking place wherein they could reflect on their clinical work. This in turn

enhanced their confidence and belief in their professional self and consequently they felt more able to contain their own anxieties and those of their clients.

The next chapter will present the concluding theory chapter '*Safeguarding against Anxieties*'.

Chapter Ten: Safeguarding Against Anxieties

“When we struggle through the grief of a patient’s death by suicide, we do double duty, personal and professional” (James 2005).

Introduction

Following on from the previous chapter, this concluding theory chapter describes how the participants responded to the death of a client by suicide. This chapter titled ‘*safeguarding against anxieties*’ discusses the different strategies the participants used to protect themselves both professionally and personally during the aftermath of a client suicide. The strategies used have been conceptualised as: ‘*Retracing their steps*’, ‘*Defensive debriefing*’, ‘*Seeking absolution*’, ‘*Searching for explanations*’ and ‘*Soothing self*’. Before moving on to discuss the above strategies, the context of clients’ suicide will be provided, followed by an account of the participants’ experience of the trauma of client suicide and the anxieties that it engendered for them.

Experiencing the trauma of client suicide

Losing a client by suicide is a potentially traumatic experience for all mental health professionals including mental health nurses, irrespective of the clinicians’ training, experience or the context of their work (Grad & Michel 2005, Foley & Kelly 2007). As captured by one participant “*when a client dies that you have known and worked with for a long time, it’s devastating, it’s absolutely devastating*” (F8). Although the participants made every effort to prevent clients from ending their life, they were unable to do so and consequently they were confronted with their worst professional fear - the death of a client by suicide. The participants encountered client suicide at various stages in their journey through treatment and care; some clients died while in hospital, some died while on leave, others died following discharge from in-patient care, or while living in the community and in contact with the services and nurses.

This meant that the participants were directly or indirectly involved with the client and as such had different levels of contact and responsibility depending on whether or not the client was being cared for by them at the time of their death.

“I’ve known of lots of clients over the years, but I was not directly involved with, but then last year I was directly involved with one client, I was his key worker he has been in hospital for weeks. He killed himself a few weeks after his discharge (M2).

“We had a client from another ward who committed suicide at the main reception which affected everybody really in a big way” (M3).

“I’ve been involved in three suicides since I moved to the community” (F17).

For some participants who worked in the community, they learned of the client’s suicide when phoning the client or when arriving at the client’s home and discovering that the client had taken his/her own life. In these incidents, the method of suicide was gruesome, easily visualised and therefore traumatic for the participant, as described:

“It was a Saturday morning, I was working, and we went down to the house but got no answer. I then rang the ward and they said he wasn’t admitted so obviously I went back to the house, no answer, called back throughout the day on several occasions, no answer, rang his sister and that evening she came up to the house, she had a key, and we went in and he’d taken an over dose. He was dead” (F17).

“I was working quite closely with this man and his wife. He took his own life and I happened to ring at the time to arrange for him to come up and be reviewed just when his wife had found him dead. He locked her into the house while he went into shed and hung himself. It was pandemonium, I spoke to the wife’s brother but I could hear her screaming in the background. It was just awful” (F7).

“I was her key worker at the time. She had been reviewed, she seemed fine and then she had gone off for the weekend. Then on the Saturday there was a phone call that she had been found dead. She had self-inflicted stab wounds to her chest with a kitchen knife, quite a violent death” (M9).

The impact of suicide on the participants was a far more complex issue than losing a client through death, yet limited research has focussed on how they might deal with the aftermath of such a significant event (Christianson & Everall 2009). Irrespective of whether they had undertaken further education or were attending clinical supervision participants talked about their intense reactions when they found out about their clients’ deaths. Although they were in their professional role when they

heard the news; they found it difficult to conceal their personal shock and distress at the time. Hearing about the client's suicide evoked a range of initial responses including feelings of numbness, shock and sadness. Participants' distress related strongly to the nature of the therapeutic relationship with the deceased client, which for some was over a sustained period of time as reflected by one participant:

"I cried when I was told about her suicide; I couldn't believe it. This case was quite unique, I had worked with this woman for 3-4 years, seen her for a long time and been there after she had her 3 children; I also knew her 2 other children. I helped her work through some terrible things in her life. She had to put up with so much - she was such a strong woman" (F8).

Each participant grieved and responded differently depending on the nature of the therapeutic relationship. Furthermore, given that each client suicide was different, it presented the participants with a unique grief experience that was complex and challenging, both professionally and personally. Spencer (2007) also points out that there are some factors, which might make it slightly more difficult for mental health staff to cope; for example, the nature of the therapeutic relationship, circumstances surrounding the suicide, how the participant learnt of the suicide and the type of support offered by colleagues and the organisation. For many participants, the news of the client's suicide arrived "by many messengers" (Dyregrov *et al* 2012, p.27), including, nursing colleagues, managers, members of the mental health team, client's GP, and in a few instances family members. At the time, some participants were not only shocked by the news of the client's death but were also taken back by the lack of sensitivity in the way the sad and shocking news was delivered. As one participant recalled:

"I had two days off and came into work and was met by a colleague who said - ah you'd never guess. You know, that lad's just died. That for one was extremely upsetting and two the way I heard it I would have thought that they would have said [xxx] you know the chap that you're working with....., well I've got bad news and their might have been a lead into it. I was really surprised, the person would have known the client and they would have known the work I would have done with him" (M13).

Working with clients in the community meant that participants also got to know the client's family and as such had established a good rapport and alliance with them. After hearing of the client's suicide, the participants immediately thought of the bereaved family and felt sad for their loss of a loved one. At the same time, the

client's suicide reminded some participants of their own personal loss and grief as a result of the death of a family member/friend by suicide. This helped them to have a greater awareness and empathy with the family about what they might be experiencing during this difficult challenging and emotional time, as reflected by the following participant:

"I would have had experience of a man who killed himself and I was working quite closely with him and his wife. They were a lovely couple; she tried so hard to help him. I was very fond of the family and the last thing you want to see is that happening to anyone in a family. In the last few years, I have experienced two family members dying by suicide; I know what it's like..." (F7).

Health care professionals including mental health nurses are likely to be exposed to the deaths of clients throughout the course of their work (Kleespies & Dettmer 2000, Farebrow 2005 & Wallace 2008). However, as Spencer (2007, p. 28) points out only mental health staff and nurses in particular, are expected *"to develop a sustained relationship with clients in a direct attempt to reduce the risk of taking their own life"*. For the participants, trying to fulfil this additional expectation increased their sense of responsibility and sense of failure when the therapeutic relationship ended as a result of the client's suicide. According to Dyregrov *et al* (2012, p. 57), *"self-reproach, reproach and feelings of guilt are extremely common after a suicide"*. Professional self-doubt was common among the participants, which prompted them to ask themselves anxious questions concerning their clinical competence and whether they might be to blame in some way for the client's suicide as reflected by the following participants:

"It's like I had failed her, that's your initial reaction definitely. I felt that I failed her; I failed her children, family by not keeping her alive. What could I have done to help get through the next 36 hours?" (F8).

"I wondered whether we put him under pressure; advised him or encouraged to have goals that were maybe were too much for him. Did I miss something? Was it the fact that I had told him he was going to be discharged?" (F7).

"I kept asking myself what did I miss, did I miss any signs or should I have been looking for the signs. It really does question your own practices and your reasons for being in the job" (M8).

Similar to personal responses that other survivors endure the participants also experienced a sense of failure to their professional identity; they anticipated and feared being judged and blamed by their colleagues as well as the organisation and the client's family. They had learnt about such fears from their nurse education and observed how other nurses responded anxiously following the death of a client by suicide. For the participants, feeling vulnerable and anticipating a formal inquiry wherein they might be expected to explain their part in the client's care also added to their fears of being judged and blamed for the client suicide. Faced with such anxieties, the participants irrespective of level of education and attending clinical supervision carried out at varying levels and degrees the following strategies as a means of safe-guarding themselves following the death of a client by suicide.

Retracing their steps

'Retracing their steps' refers to the way the participants went back over everything that they said or did with the client prior to his/her death as well as what they wrote in the client's notes. Participants retraced their conversations with the client and examined what they had written in the client's clinical notes. They also recalled conversations concerning the client with the client's family, their nurse colleagues and other members of the multidisciplinary team. In the aftermath of the client's suicide, the participants experienced a deep sense of professional and personal vulnerability. For the participants, particularly those working in community mental health, working in a more "risk-conscious" society (Wilkinson 2001, p.5) heightened their awareness of suicide as a major issue in mental health alongside their anxiety concerning the need to keep both the client and themselves safe. As summarised by two participants:

"Working with suicide, sometimes it's like anticipatory anxiety, you're anticipating the worst, but I wouldn't always have that" (F8).

"There's two types of fear, there's your own fear about being a professional but there's fear concerning ...will I be ...have I failed the client, I don't want someone to die... but I will be accused of failing? It's a double, two prong thing" (M2).

Although shocked and saddened to hear of the client's death; in the wake of the suicide retracing what they had said and/or done helped the participants to evaluate what they might have missed or misunderstood when caring for and working with the client prior to his/her death. Feeling a sense of unease and worry, they wrestled with their feelings of loss and grief, having concern for the client and the bereaved family and at the same time they needed to understand what might have gone wrong and more worryingly the extent of the role they may have played in it. As participants recalled:

"...at the end of the day it's a therapeutic relationship I have with people, you get to know people, you have a fondness for them, you get a fondness for their family and the last thing you want to see is that [suicide] happening to anyone in a family" (F7).

"I suppose it's like an automatic response. You know, it's a normal reaction, and it wasn't a cover my back kind of thing; it was more just for my own..., was it something I missed or could I have stopped this from happening" (M9).

"When you go into somebody's house and you see the woman's husband and child you think did I do something wrong? We failed here. So it can be very difficult sometimes" (M2).

After a client suicide and as part of the organisation's policy following untoward clinical incidents (Bowers *et al* 2006), the participants were required to complete an incident report and ensure that their notes were up-to-date. Nursing colleagues also advised the participants to "*check their notes*" and reiterated the importance of making sure all entries were recorded and up-to-date, as these two participant stated:

"I had to do a report of my work and what interventions I did. And even that was a bit worrisome because it was something that I had never had to do before. And I remember at the time I was just flummoxed and the first thing that was said to me was - are your notes up to date? And I have to say I felt like saying fuck off..," (F7).

"I did my notes reflected on what I did accurately and then will they think I am covering up what you didn't do as opposed to explaining exactly what you did do" (F8).

Although the participants believed that their colleagues' advice was well-intended they experienced it as unsupportive and critical. Furthermore, it confirmed their fears of being judged by colleagues, which further added to their feelings of anxiety and self-reproach. As one participant stated, *“even though I do feel it was said for my benefit, I just think there were other things that could have been said before that was said”* (F7). In the wake of the client's suicide, the participant recalled wanting someone to respond empathically and demonstrate some compassion and support; *“I just wanted her to ask me are you ok; do you want to go for a cup of tea, I don't know, just something a bit more personal”* (F7). Feeling frightened and fearing blame, the participants needed to be listened to without judgement; in fact, several participants recalled feeling so anxious after a client suicide that they felt consumed or *‘taken over’* by fear; as one participant recalled:

“My whole weekend was taken over worrying. It was terrible, this was on a Friday afternoon and it got me into ‘oh God’. I had to sit with it the whole weekend. I didn't know what to do, I went home and I'll never forget that weekend, it was desperate” (F7).

Consequently, it is not surprising therefore that some appreciated the support given by their immediate managers and colleagues, as described by one participant:

“My CNM2 on that team again from the outset very, was very supportive and put her arm around me, told me not to worry and all that stuff. I really appreciated it” (M9).

Retracing what they had said and what interventions they had carried out with the client helped to lessen some of their anxieties; however they still feared being judged and held accountable by the organisation and family, which gave rise to overwhelming feelings of anxiety about litigation and/or professional malpractice.

Defensive debriefing

‘Defensive debriefing’ refers to the way the participants talked about events leading up to the client's suicide at the *‘debriefing meeting’*. Wherein debriefing took place, participants experienced it as negative, unsupportive and unhelpful. At the debriefing meeting, the participants answered questions about the client posed by the facilitator. They replied cautiously and defensively to the questions asked and provided short, factual answers about their contact with the client prior to the suicide. In most

instances, the participants knew the facilitator; however, they were wary and distrustful of the facilitator's role and questions about their clinical work especially, since the facilitator was a senior medical colleague who also held medical responsibility for the deceased client. As participants described:

"I thought they would have got someone who doesn't work in the organisation; I know other places get an outside therapist. We had the consultant, who, from my understanding of debriefing is we're all equal but this was very hierarchical, it wasn't ideal. I certainly didn't feel comfortable about opening up. I just said the bare facts about .." (F10).

In the aftermath of the client's suicide and in keeping with the organisation's policy post a critical incident, the participants attended one debriefing meeting with colleagues who were also directly involved with the deceased client. Given the sensitivity, shame and stigma associated with losing a client to suicide (Briggs 2010), it is essential for staff to feel safe and trust those with whom they share their experiences (Dyregrov *et al* 2012). Although the participants wanted to spend time talking through their experience of working with the client and the events leading up to the suicide, they followed the facilitator's directive style and format of debriefing and replied only to the questions posed to them. Feeling fearful and unsafe, the participants chose not to share or disclose their anxieties and feelings of sadness. Instead, they restricted and censored their communication as a means of shielding themselves against the anxiety of being judged or blamed by the facilitator and in front of their colleagues. As described by this participant:

"It's more about checking our "I"s and crossing our "T"s, so it's very patriarchal. It's, what have you done, and more of a kind of interrogation. There's no time for talking about feelings. We've had debriefing and we kind of run through what happened. So called debriefing, it wasn't a debriefing at all it was like a fact finding, cover your ass kind of exercise, that's what I and a few others felt it was like. It wasn't a debriefing, a debriefing isn't about fault finding - it's talking about what happened. The consultant setting the scene it was as if he didn't know what a debriefing was but it was called a debriefing. But it could have been called a fact finding mission. These are people they are qualified a long time, they described it as an interrogation. It was more traumatic nearly than the actual event" (M13).

According to Reeves (2010) a debriefing policy aims to help safeguard the emotional and psychological well-being of all those affected by client suicide. For many

participants, the debriefing meeting was experienced as a critical process and they considered it more like a process of determining accountability “whereby the workplace discharges its responsibility to the worker” (Rycroft 2005, p.92). Consequently, the participants were suspicious of the purpose of the debriefing and questioned its usefulness in helping to safeguard their emotional and professional well-being and allaying their fears. The participants believed that the “*so-called debriefing meeting*” (F10) was more concerned about safe-guarding the organisation as opposed to protecting the staff affected by client suicide.

Seeking absolution

‘*Seeking absolution*’ refers to the way the participants made contact with the family during the aftermath of the client suicide. Although uncertain about whether they should contact the family, the participants phoned the family and offered their condolences, invited the family to meet them and visited them at their home. As described:

“It was the whole thing do I get in contact with her. I just felt I had to, so I got in touch with his wife and said if she would like to come in” (F7).

As well as feeling sad for the family, the participants simultaneously feared that the family might blame them for the client’s suicide and were anxious to know how the family felt towards them. The participants therefore contacted the family hoping consciously or unconsciously that the family would absolve them for not preventing the client’s suicide. . According to Berman *et al* (2006) such fears are well-founded as reproach after suicide can be directed towards outsiders such as mental health workers, and moreover many suicide survivors consider malpractice litigation when their family member dies under the care of mental health services. For the participants, knowing the family compounded their feelings of guilt and self-reproach about not being able to prevent the client from ending his/her own life. As captured by one participant:

“So I suppose the first time when it happened I would have been the key nurse to this man who took his life. I would have dealt with his sister before as she was a patient. So I would have known his brothers and sisters and his mother. So it was the whole thoughts of facing them - would they blame me, I was afraid to – would they blame me. I was afraid they would say - well did you not see this happening? (F7).

Much to the participants' relief, few participants received any criticism or blame from family members; instead they received gratitude for their help and nursing input with the client and family. For the participants, knowing that the family did not blame them was comforting and also helped to absolve them from their feelings of guilt and self-reproach that they had professionally failed their clients. This subsequently meant that the participants did not need to safe-guard themselves against anxieties concerning possible professional allegations and litigation from the deceased client's family. As participants described:

“Having spoken to the mum, she was very nice on the phone and from the outset very grateful about the amount of input I put into her son. And from that day to the funeral the following w/end there was a real sense of gratitude towards me. I think that made me feel a lot better” (M9).

“Everything in her conversation was directed at me. It wasn't in a bad way, it was like that I was the one that was going in every day and there was no blame at all on me. She was so nice about it. I felt so relieved” (F7).

“When I had spoken to the husband and seen the family and then I realised I wasn't going to get attacked, that really helped. I think it was more important for me to know that they didn't hold me responsible or that they didn't blame or that they felt my input wasn't enough, it sounds very selfish but it was important for me that they felt I had done all I could from a professional point of view” (F8).

In a few instances, wherein the bereaved family complained about the care and services provided, the consultant-in-charge usually agreed to meet the family. In such instances, the participants felt protected from any direct criticisms, however, hearing of the family's dissatisfaction caused them to feel guilty and doubt themselves. As one participant described:

“The family after the Coroner's Court were not happy that we had done everything; as far as I was concerned, we had done everything we could. But I think the one thing that struck me – I felt guilty, I don't know how to explain it. I started to feel guilty on the basis that the family weren't feeling satisfied. And then I started to question myself. They met with the consultant psychiatrist who saw her that day and I guess they were more inclined to listen to him than to me. He talked them through it and explained to them the situation” (M9).

Several participants chose to attend the client's funeral believing that it was an appropriate thing to do and they considered it an important part of their therapeutic ending with the client. At the same time, some participants were anxious about how the family might react to them, yet they did not discuss such fears with their managers or colleagues and decided to attend the funeral without telling them. Participants who were attending clinical supervision discussed and processed their experience of the client suicide with their supervisor including whether it was appropriate to attend the funeral. Having no post-vention protocol to guide them, several participants felt uncomfortable and uncertain about how and when they should disengage from the family after the client's suicide, as one participant asked: "*do you see them once after it happens, do you see them twice or do you just cut it off?*" (M13). For some, they believed that their contact with the family then ended since they no longer had a professional relationship/ contract with the client, as one participant stated: "*there's no more we could do here, we're finished here*" (M2). Some participants were surprised when their colleagues advised them to reduce contact with the bereaved family as soon as possible for fear that it might be misunderstood, as one participant recalled: "*some colleagues told me not to get too involved because the family might think I might be covering something up*" (F7). A few participants maintained some contact with the family, albeit distant and unknown to their work colleagues and clinical manager. Interestingly, the participants also restricted and censored their communication with their colleagues as a means of safe-guard themselves against their anxieties about being judged by their colleagues.

Searching for explanations

'*Searching for explanations*' refers to the different explanations the participants put forward in their attempt to explain the client's suicide. The participants approached the client's suicide as something that required a plausible and individualised explanation. Drawing from their knowledge and clinical experience of suicidality, they applied different perspectives and scientific positions including the bio-medical and socio-cultural perspectives as well as the perspective that places the person as an autonomous individual and responsible for their decision to choose death over living.

Unlike other types of sudden deaths, suicide is self-inflicted, which leads to many people including the participants to ask the question - why it happened? (Gaffney *et*

al 2009, Dyregrov 2012). Similar to many people bereaved by suicide (Fielden 2003), the participants struggled to make sense of the clients' decision to choose death over living, and like others they also searched for answers and explanations for the suicide. As Roen *et al* (2008) points out, "failing to explain suicide can give rise to a sense that suicide might be about chaos and uncertainty of human psychic life" (p.2095). Through their attempts to rationalise suicide the participants were able to create meaning, which played an important role in maintaining a sense of order in relation to their day-to-day work experiences (Foucault 1967). Having an explanation that was individualised helped the participants to make the client's death understandable (Mellor & Schilling 1993) and provided them with comfort and containment that is, being held emotionally. This then helped the participants to protect themselves against the burden and anxieties of being responsible for not predicting and preventing the client's suicide.

The bio-medical discourse offered the dominant way of understanding for the clients' suicide by proposing a cause and effect relationship between mental illness and suicidality. From this lens, the participants conceptualised suicide as a problem located within the person and associated with mental health problems (Bracken & Thomas 2004), particularly between depression and the inevitability of suicidal behaviour (Bennett *et al* 2003), as described by the participants:

"The amount of experience that I have on the frontline is that suicide happens, it's a fact. People with mental illness are at risk of taking their own lives. It's a given and there's very little you can do to prevent it" (M9).

"The guy that killed himself, he was diagnosed with depression but there was no psychosis" (M13).

As well as taking a mental health understanding of suicide, the participants also framed suicide as a sociocultural phenomenon that occurred within various cultural contexts and impacted on families and communities (Durkheim 2002). As described:

"She was a traveller, she had 5 children and throughout the 4 years I had worked with she would always say her kids were central, they were her life" (F8).

Working from a community focussed model of practice (DOHC 2006) the participants were acutely aware of the potential suicide risk among clients with

mental health problems living in the community and the challenges it posed for them to keep them safe. However, they also recognised that while hospital admission may help to keep the client safe and as such help them to safe-guard against their anxieties; it only provided a temporary solution and did not always guarantee the client's safety. In fact, some participants believed that in some situations, hospital admission(s) could have a detrimental effect on the client's well-being and paradoxically become a possible trigger and/or risk factor for suicide, as pointed out by the participants:

“If the patient is gone into hospital it might put them off doing it for a week or two or however long the admission is. It might make me feel better, it might make the family feel better but it might be just making the patient worse while they are in there and more determined when they get out that they are actually going to do it because for some people going into psychiatric hospital or if they have already been in there and going back in again is the last straw for them – is that what my life is always going to be every time I have a crisis I have to come in here, I don't want that” (F7).

“No there's no 100% and I don't think there can ever be even if you persuaded someone to go into hospital or even if they went in voluntary, there's no guarantee of safety there's no 100% either. Obviously it would generally be a safer place but it doesn't guarantee it either” (M10).

The third perspective places the person as an autonomous individual and responsible for their decision to choose death over living. Implicit in this view is that the suicidal client is an autonomous rational individual who has made a choice. By framing the choice to live or die by suicide as a rational decision-making process, the participants perceived the clients' suicide as rational choices in response to their life circumstances. This supported the belief that the person had considered their decision and made the wrong decision. Taking this premise, the participants believed that if the suicidal client makes a choice, then he/she is responsible for that choice and can be judged on it, which relates to the idea of 'responsibilisation' (Rose 1996). This construction of suicide and the suicidal object helped to serve the function of self-protection for the participants, wherein they perceived the responsibility for the clients' suicide to be placed with the client rather than their professional selves. This explanation also helped to allay the enormity of their burden of feeling responsible for failing to prevent the client's suicide. As described by the participants:

“No matter what we do, we don’t kill anybody, people kill themselves and it does take a level of risk to return people back to the community” (M9).

“As I was saying no matter what you do for some people if they are going to do it, they are going to do it. This lady had planned meticulously exactly what she was going to do. There was nothing spontaneous about it at all, which in a way reassured our own conscience about did we make the right call? Because when you look back it looks as this woman was going to do it either way, no matter what we did” (M2).

“I had a client who carried out a cyber-suicide pact – that’s what it was called. He arranged over the internet to meet a guy a total stranger; they met up to arrange their suicide together. They met up and planned everything. They both had written letters, telling what they were wearing, where they were going, where they could be found, where their bodies could be found and posted the letters the day before. “I had a client who carried out a cyber-suicide pact – that’s what it was called. On the day, they drank a lot of alcohol, filled up their rucksacks with stones, and padlocked them onto themselves, and jumped into the lakes” (M13).

“...we cannot be held responsible. I feel we as a service cannot be held responsible for the individual’s actions. Some people are just going to do it and unfortunately no matter what you put in place” (F8).

Construction of the person as an autonomous individual and responsible for their decision to choose death over living also helped the participants to distance and protect themselves emotionally so that they did not have to deal with the reality and fears of the client’s death, as described by one participant:

“When you go into somebody’s house and you see the woman’s husband and child, it, doesn’t make sense .You are trying to make sense of it, because it’s very sad, seeing the child. Hanging, it’s final, with this client it’s the finality in there’s no more we can do. We’re finished here” (M2).

“She hung herself, quite violent for a woman. She had 5 children and her children I felt would only have a decent life when she was there. She was a traveller and the mother is such a central role for children. I was angry with her for that” (F8).

For some participants, the clients’ suicide was particularly shocking because it did not fit in with their perception of how things were when they last saw the client, as one participant recalled: *“It was an unbelievable shock, someone I had been seen at*

4pm the previous day, I got into work the next day morning and she was gone. She killed herself at 6pm that night. Not a word, not a word” (F8). Believing that the client was fine at the time, the participants realised that they were not fine and as such, they experienced what “a break in reasoning – a rift in the unexpected sequence” (Roen *et al* 2008, p.2095). Struggling to make sense of the event and maintain the belief that the client’s thinking processes were at the time rational, the participants returned to the biomedical discourse for a possible explanation.

“I still can’t make sense of this client’s suicide. The only thing, I can think of at the time was that she became quite acutely psychotic. At the time her thought processes must have been completely impulsive. She was under a lot of pressure from her family; she obviously thought this was the only way out” (F8).

For the participants who had personal experience of losing a loved one by suicide, the view of the suicidal person as an autonomous individual and responsible for their decision to choose death over living fitted with their personal experience of suicide. They positioned themselves as knowing about suicide and understood it as something that was possible, imaginable and not preventable, and sadly known directly within their personal and professional lives. As participants describe:

“In my own personal experience, one of my cousins I don’t see the reason why he took his own life, he appeared to have everything going for him but obviously he had his reasons and I firmly believe that he at the last minute panicked but it was too late so he hung himself and his parents found him. And we are a very close family” (F7).

“My best friend killed himself; he was the same age as myself. I certainly didn’t see it coming and he never spoke about it or never said anything about it and then all of a sudden we heard he was dead. He planned every detail, he had a great family and yet no one ever thought he would kill himself.... We knew each other since school and he never said anything to me” (M3).

Although the various explanations and in particular the biomedical perspective provided the participants with possible causal factors for the client’s suicide, no one explanation on its own provided a single definitive explanation. Nonetheless, such explanations helped to safeguard the participants against their anxieties of feeling responsible and blamed by the family or organisation.

Soothing self

'*Soothing self*' refers to the different strategies that the participants used to process their experience of losing a client by suicide. The participants cried, talked through their feelings and thoughts with colleagues and family. They also ruminated about the client and events leading up to the suicide, distracted themselves and monitored their practice with suicidal clients. In contrast to other types of death, the death of a client by suicide left the participants burdened by a special type of guilt, a sense of sadness and professional failure, feelings of responsibility, and speculations about why? as well as other reactions to the client's death.

"I couldn't talk about it without getting upset, and then you question yourself because you're upset - am I getting upset because of the client or my failure?" (F8).

"After the client's suicide....of course there is naturally a sense of failure, so I was expecting ... I was a little surprised that I was feeling this way I had those feelings but I wasn't too concerned about the fact that I had them, I just thought it was a normal thing, it's a human response" (M19).

During the aftermath of the client's suicide, the participants learnt how to comfort and protect themselves emotionally and psychologically so that they could continue to do their clinical work and begin to move on from the traumatic event of client suicide. Dyregrov *et al* (2012) points out that support plays a crucial part to the healing of those close to the deceased and who have been strongly affected by this type of death, which includes those in the helping professions. Although the participants perceived the need for support they did not seek nor were they offered formal support beyond the debriefing meetings. Nonetheless, they found support from talking about the event with their immediate colleagues helped them to feel less isolated and enabled them to continue to work effectively:

"It was hard, at the time I was working in a team and everyone was very supportive to each other and that was a great help. That was a great , it was great to be able to come and feel you were getting support from your colleagues and it reassured you and mostly, most of them were saying the same" (M10).

Discovering that other competent professional colleagues had also experienced a client suicide helped the participants' to regain a sense of trust and confidence in

their professional role, which in turn reduced their anxieties, as described by one participant:

“I remember discussing this with some very experienced colleagues afterwards, and asking them how, what did you do to cope with this? This was the first suicide I had been involved with in the community but I remember saying it to the other nurses and asking them “How do you cope?” (F8).

For others however, they felt isolated at times because their colleagues did not understand what they were experiencing; they also worried about their colleagues misconstruing their need to talk about the client’s suicide; *“you can’t keeping going on about with your colleagues, they might think you are upset or worried because you did or didn’t do something” (F17).* Their sense of isolation was compounded by the lack of other formal support resources, such as clinical supervision or peer support/reflective groups, which meant that the participants did not have the opportunity to process their experience of client suicide, as described:

“This is [research interview] the only in depth time I’ve discussed this guy’s death. Some of the things that I have talked about it I haven’t thought of before. I’m aware that sitting here today wasn’t about helping me get over the client’s suicide or about the processes....but it’s been very helpful” (M13).

“Stuff that I verbalised here [research interview] I probably never really thought about but as we were speaking has come into my head” (F8).

The participants experienced a range of anxieties as they continued to work with other potential suicidal clients. Over the course of time their fears ebbed and flowed as they processed their experiences and integrated the experience of losing a client by suicide into their practice. For the participants, the experience of not being able to prevent the client’s suicide was difficult; it confronted them with the reality of being in a position wherein they could not influence the client’s behaviour, which in turn undermined their professional identity, role and confidence, as reflected by these participants:

“The client’s suicide, it questioned my core beliefs and beliefs about myself as a nurse - you go into this career to make a change - to benefit the client, you never went into this career to do any harm to anybody, nursing – it’s not

about that. And when you can't make a change or influence a change - like suicide that's very final – it really does question your own practices and your reasons for being in the job” (M2).

“It knocks your confidence completely because you're constantly questioning yourself about it” (F8).

“You'll never hear from the people you've helped, you'll only know about the ones that you don't help. One of the reasons I enjoy this job the for most part is that you can make a difference with people and it doesn't have to be a huge big input, it can just be a pat on the shoulder or a smile on someone's face, you know just an acknowledgment of something at a particular moment in time” (M13).

Given the organisational culture of not discussing the topic of a client's suicide, it was not surprising that some participants compartmentalised their own experiences and focussed on continuing their work tasks, while seeking support outside of work from family and friends; *“my partner didn't know what to say to help me – but he listened. I just needed to talk about it, especially in the first months” (F7).* Some participants coped by distancing themselves from the experience, which helped them to safe-guard against feeling overwhelmed by their anxieties, as described:

“You do have to step beyond the experience; I think I was very lucky I was moving jobs. I was here the next week so I wasn't in the middle of it. I think if I was still there I think it would have been very difficult” (F8).

As time passed, the participants identified what learning they gained from their experience of losing a client to suicide. The client's suicide not only heightened their awareness of the risk of uncertainty when working with suicidal clients but it also prompted some participants to question the effectiveness of the assertive community care model for all clients with suicidal behaviour.

Losing a client to suicide also challenged the participants' sense of omnipotence and purpose for being a mental health nurse.

“It was definitely a learning experience. I don't mean to be bad when I say that, a learning experience when somebody had died but it's definitely made me more aware when I go in to somebody's home and while I think Home Care is great for some people - but when you are actually coming into their home –because some people are not assertive enough to say that they don't

want you to come into their home so go along with it. But for them they've nowhere to hide. They have nowhere hide you are now in their home. I never thought about that before" (F7).

"Life experience, it was a big life experience. I think the biggest thing I learnt personally was we can't fix everything, we can't prevent it" (F8).

Working with suicidal clients continued for the participants, however, not surprisingly the participants' fear of the potential risk of suicide was heightened and therefore they were less willing initially to take any positive risks with the client; *"certainly in the initial stages after I was hyper-vigilant, cautious with people, taking no risks at all" (F8).* Moreover, they were also aware that they found it difficult to trust other clients in similar situations and lacked confidence in their own clinical judgement:

"I suppose in hindsight it left a mark - just because somebody appears to be well doesn't mean that they are safe. Patients/clients will only tell you what they want to tell you no matter how experienced you are. You can never tell what's on a person's mind. Obviously the patient to let you know if they are feeling suicidal and in that case there was no indication" (M10).

"I have regained my confidence in my practice because it knocks your confidence completely because you're constantly questioning yourself about it" (M9).

"Obviously I will never forget her and every time I drive past the site I think of her and her kids and the fact that the self-doubt has receded. I have regained my confidence in my practice because it knocks my confidence completely (F8).

Summary and conclusion

This concluding chapter of the theory 'Attenuating Anxieties' described how the participants experienced the traumatic event of losing a client by suicide and the impact it had on them both professionally and personally. Losing a client to suicide evoked a range of grief responses for the participants, which varied in intensity according to the nature of the therapeutic relationship with the deceased client. Although the participants perceived the need for support they were offered minimal support beyond the debriefing meetings, which were experienced as unhelpful and perpetuated their fears of being blamed by the organisation. The participants

therefore found the strategies; *'Retracing their steps'*, *'Defensive debriefing'*, *'Seeking absolution'*, *'Searching for explanations'* and *'Soothing self'* as a means of safeguarding themselves against the anxieties the client suicide engendered for them.

The next and final chapter will present the discussion of the key issues that emerged from the theory *'Attenuating Anxieties'* together with the limitations, implications, recommendations and trustworthiness, and personal reflections on the process of conducting the study.

Chapter Eleven: Discussion, Limitations, Implications, Recommendations, Trustworthiness and Reflections

Introduction

This final chapter will present the discussion of the key issues that emerged from the theory '*Attenuating Anxieties*'. Although several aspects of the theory have been discussed in the preceding chapters, this chapter will discuss some key issues in the context of other literature on the substantive issues and literature on anxiety. In addition the limitations, implications, recommendations arising from the study will be discussed. The penultimate part of the chapter will involve a discussion on trustworthiness as it relates to the theory. The thesis will conclude with personal reflections of the process of conducting this study, and with insights gained about self, the methodology, suicidology and nurse education.

Attenuating Anxieties: Implications and outcomes

Although several aspects of the theory has been discussed in the literature section (chapter three); this is the first study, which integrates all the different aspects of mental health nurses' responses in relation to clients with suicidal behaviour in both in-patient and community mental health services and develops a theory to make explicit nurses responses. The theory '*Attenuating Anxieties*' adds to the body of nursing knowledge by identifying how the participants dealt with their need to protect clients and themselves and the various strategies they used to allay their anxieties when working with clients who presented with suicidal behaviour.

The concept of risk has gained increasing attention and importance in both the academic and professional literature in general and mental health in particular since the publication of Ulrick Beck's (1992) seminal thesis '*Risk Society*' (Adams 2001). Furthermore, the notion of risk has become increasingly the focus in health care policy (HSE 2009). Historically, the idea of risk was viewed as something that was considered as being 'good' or 'bad' and involved either a 'loss' or a 'gain' (Lupton 1999). However, in contemporary society and in the context of health, the meaning of risk has changed from being considered neutral into something that is often

viewed as entirely negative, and as an issue or incident that has the possibility of a negative development of events or the probability of an adverse effect (Douglas 1990, Lupton & Tulloch 2002, Titterton 1999, 2005). Therefore, in today's world and in the midst of everyday activities it is commonly accepted that we live in a world of threatening uncertainty and as such we are increasingly vulnerable. It is not surprising therefore that we have become culturally disposed to express our anxieties in the language of risk and risk-aversion. As Wilkinson (2001) asserts the more we recognise ourselves as being 'at risk' the more vulnerable we become towards anxiety; consequently anxiety has become intimately connected to the extent that we are becoming more 'risk conscious'. As Lupton (1999) points out one of the many key points of feelings of anxiety and uncertainty is risk. According to Beck (1992) one of the main features of the risk society is that new risks or uncertainties are often constructed by societal developments as opposed to nature, which he referred to as 'manufactured uncertainty'. For example in *'Attenuating Anxieties'* the move from institutional to community mental health care has brought about new risks and uncertainties for clients, families and society at large, including professionals caring for people at risk of suicide. For all professionals as members of the 'risk society' (Beck 1992, 1999) whether in maternity care, general medicine and psychiatry there is also increased pressure to predict and prevent any adverse outcomes in order to make life more manageable and certain. This pressure is fuelled by the culture of Evidence-Based Practice (EBP) (Sackett *et al* 1996, 1997) and the imperative to reduce uncertainty, which in turn adds to professionals' anxieties. In addition, as Sturmberg (2011, p. 507) posits certainty is also considered "part of a human desire to provide comfort and surety". Indeed, it is not surprising that Gigerenzer (2002, p.14) states "certainty has become a consumer product. It is marketed the world all over – by insurance companies, investment advisors, election campaigns and the medical industry". However, in health care uncertainty is unavoidable, yet as Buetow (2011, p.873) argues the unpredictable nature of care as well as the lack of complete knowledge about the care is invariably viewed as negative and problematic. Consequently, predictability and certainty of knowledge of events are pursued in order to keep a focus on safety. According to Beck (1992) it is anxiety and fearfulness of risk that motivates the person to acquire knowledge in order to avoid becoming the victim of risk. In *'Attenuating Anxieties'* the participants main concern was to protect the client from the risk of suicide or harm to self and at the same time to protect their professional self. However, they were aware that in the context of

mental health the nature of suicide opens up both complexity and uncertainty. Furthermore, suicide prediction is an inexact science and very few if any valid tools exist within mental health, with Kemshall (1999, p.5 cited by Woods *et al* 2009) positing that “practitioners have an obligation to act responsibly and defensibly on risk, but not guarantee its prevention”. In this study, all participants albeit to varying degrees, and depending on their education, clinical experience and engagement in clinical supervision experienced and *managed anxieties* to help keep clients and themselves safe and at a cost.

As described in an earlier chapter, anxiety is not a new phenomenon in mental health; it is a complex physiological, psychological and emotional experience. Anxiety is often experienced subjectively as unpleasant yet a ubiquitous part of human experience, which can be either an adaptive or maladaptive response (Dryden 2009). The primary purpose of anxiety is to keep the person safe by alerting them to the threat of risk or of being hurt and to prepare them to take action. However, anxiety is not always negative, indeed in some situations it can act as a motivator for example, in this study some participants’ anxiety about feeling unskilled to work with clients in a more advanced and therapeutic way motivated them to return to education in order to acquire further therapeutic knowledge and skills. This together with clinical supervision enabled them to learn to live with the tensions of uncertainty and hold the tensions of uncertainty as a positive creative force. In addition, it also facilitated them to engage in a dialogic process with clients, so that their confidence and competence to work with anxieties was both positive for self and for client. In contrast, other participants who experienced anxiety as a perceived threat to self and client and who were working from the clinical perspective that they should be able to predict and prevent any adverse outcomes managed their anxiety by emotional distancing and ‘*caring for*’ as opposed to ‘*caring about*’ the client. Consequently, they missed the potential and opportunity to develop an engaged relationship with clients and in so doing they failed to engage with the relational dynamic that evolves when working with clients.

In the seminal work of Isobel Menzies–Lyth (1959) the consequences of ignoring the psychodynamics of caring in institutional settings is highlighted. Menzies (1988, 1989) developed Freud’s ideas on anxiety and studied it within the social context of organisations. Her classic study described the distress of nurses in a general hospital,

which she conceptualised as anxiety. In her work on nurses' anxiety, Menzies (1959) also mapped the responses of nurses to their anxiety, which she named as social defence mechanisms. The intimate nature of nursing and caring for sick patients involved close physical and interpersonal contact. Consequently, the nurses introduced unconscious defensive measures to manage their anxieties. Menzies (1989) posited that the defences against the anxieties of the primary task that is the nursing care of sick people resulted in a service dominated by formal and rigid procedures. Such procedures minimised personal contact with patients and became part of the routinized rituals within the culture of nursing practice. Although Menzies' (1988, 1989) study focused on the particular concerns or anxieties and conflicts that are specific to caring for ill people, these anxieties can be applied to other particular areas of work or organisations because their defences match aspects of the social defence system of an organisation. As Hinshelwood & Skogstad (2000) posit the nature of the particular kind of work shapes and influences what defences can be employed. In '*Attenuating Anxieties*' the participants' primary task or work-specific anxiety was different from general nurses and concerned keeping suicidal clients and themselves safe and therefore influenced what defences could be employed to allay their anxieties.

Looking at '*Attenuating Anxieties*' through the lens of Menzies' work, it can be theorised that the practices of '*keeping watch*', '*making deals*', '*profiling believability*' are part of the organisational defences against anxiety and potential threat. According to Menzies, organisational defences or as she latterly called them 'defensive techniques' encompass techniques such as rituals, skills customs, systems of practice, language, values, prejudices; which act as defence mechanisms against anxiety. However, while the various defensive techniques may be carried out by individuals, they exist within the reality of the whole organisation. Therefore, the practices of '*keeping watch*', '*making deals*', '*profiling believability*' were collectively understood, supported and promoted by the mental health team and organisation along with the denial of uncertainty.

Furthermore, in '*Attenuating Anxieties*', practices were transferred into the community, wherein the expectation was that families members would also become part of the surveillance network and partake in implementing procedures such as '*keeping watch*', which no doubt was anxiety provoking for families and carers.

Hinshelwood & Skogstad (2000, p.9) argue that it is this “collectivisation of anxieties” that generate implicit sets of attitudes and lead to the characteristic practices and culture of the work, which in this study involved defensive practices albeit at varying intensity in order to keep clients at risk of suicide and self safe. These defensive practices also served the function of depersonalising and de-humanising nursing care as well as providing distance from the conscious and unconscious anxieties that the participants faced on a daily basis and in the absence of supportive reflexive systems such as clinical supervision. These anxieties concerned the need to keep the suicidal person and self safe. In addition, they served to allay a fear of helplessness, a lack of capacity to tolerate emotional distress and not-knowing, as well as a heightened sense of the feeling of burdensome responsibility. The fear of blame for client suicide including self-blame, and by the organisation, profession, society and client’s family also prevailed.

Self-harm: The absence of understanding

It is clear from the findings that the participants who did not pursue further education in a psychotherapeutic model or were not attending clinical supervision were limited in their understanding of the complexity of self-harm behaviour. Consequently, they did not understand that self-harm is a form and method of communication, which has meaning and serves a unique function to each person (Pembroke 1996, Shaw & Shaw 2007, Inkle 2010b). Ironically, the participants attributed the clients’ self-harm to the lack of adequate coping skills, while in fact, it is actually a strategy or coping mechanism that the client uses to manage his/her distress; albeit one that is perceived to transgress the social and cultural rules of acceptable behaviour (Turp 2003).

Although the participants acknowledged that self-harm was not in itself a mental illness and encompassed primarily behaviours that involve the body such as self-cutting or self-burning; they did not recognise or appreciate that such behaviours usually resulted from mental distress within the individual. While the participants understood self-harm and suicide as different; however, when ‘*profiling believability*’ they relegated clients who self-harm as a less serious suicide risk than clients whom they profiled as ‘*genuine*’. At the same time they made minimal if any, effort to identify or explore the individual reasons for the person’s acts of self-harm and consequently, they did not respond to the client’s despair and distress that the

self-harming behaviour embodied at that time. By not exploring the meaning and function of the client's self-harm, they failed to understand that the person who frequently self-harms may also at other times, harm themselves with suicidal intent (Babiker & Arnold 1997, p.6). Consequently, the participants were unaware of the potential danger of considering self-harm as less serious than suicide attempts and of the changing complex dynamic between self-harm and suicidal behaviour for each person.

The participants' lack of understanding of self-harm meant that they experienced feelings of anger by the repetitive nature of clients' self-harm behaviour. Although research has shown that self-harm is not a singular occurrence (Fox & Hawton 2004, Inkle 2010a), the participants struggled to understand the reasons for clients to '*intentionally*' continue to self-harm. Consequently, they failed to understand that people who hurt themselves '*intentionally*' do so because they feel that they need to and in fact by carrying out the act of self-harm people experience psychological relief albeit temporary, and are more able to cope (Butler & Malone 2013). This subsequently leads to the person finding an apparent solution, that is, inflicting pain on his/her body (Gardner 2001). For the person inflicting pain may be considered to be the best or only solution and choice that he/she can make at that particular time to express or communicate their feelings of distress. Paradoxically, the participants' lack of understanding of self-harm meant that they did not understand that the term 'self-harm' itself does a disservice to the client when in fact, the person who self-harms can be said in some ways to be carrying out the "very reverse of self-destructiveness", that is, making an attempt to self-heal and/or self-care (Pembroke 1996, Babiker & Arnold 1997, p.7, Turp 2003, Inkle 2010a). Consequently, the client's self-harm may function as part of the client's recovery. Notwithstanding this, the participants worked within an illness model wherein self-harm tends to be regarded as a symptom of mental illness. As such they located the client's self-harm in pathology and positioned themselves as the expert rather than viewing the person who engages in self-harm as expert in their own recovery journey.

Similar to other research and indeed as reflected in nursing texts, the participants linked self-harm with the diagnostic label borderline personality disorder (BPD) (Crowe 2004, Westwood & Baker 2010, ELees *et al* 2014). However, it is difficult to determine whether they understood self-harm as a causal link or part of the signs

and symptoms of BPD, or whether they had learnt it as part of the cultural practice within psychiatry. Nevertheless, by *giving* people who self-harm a diagnosis of BPD even though the person may lack any other signs and symptoms of this diagnosis, the clients are further stigmatised and marginalised by the participants. Indeed, the recently revised DSM-5 (American Psychiatric Association 2013, p.803) introduced new conditions, which places non-suicidal self-injury (NSSI) or self-harm as a symptom of mental disorder and a potential disorder in its own right. As Crowe (2014) points out self-harm or NSSI has evolved from “an expression of distress to a symptom to a disorder in the DSM”. Notwithstanding the possible explanations for this proposed diagnosis, the construction of self-harm as a potential psychiatric diagnosis raises a number of concerns particularly since self-harm is usually a secretive behaviour and furthermore individuals invariably do not seek clinical attention. Therefore, diagnosing self-harm as a mental illness could further stigmatise and marginalise the person’s distress and willingness to seek assistance. Mental health nurses need to examine their role in relation to this new diagnosis of self-harming behaviours and consider how it helps if at all with understanding and responding to the person’s unique reasons for acts of self-harm.

Consistent with other studies, in this study defining self-harm as a symptom of Borderline Personal Disorder shaped the participants’ attitudes and therapeutic responses (Crowe & Bunclark 2000, O’Donovan & Gijbels 2006, James & Cowman 2007, Bowen 2013). Consequently, the participants judged the clients and their behaviour negatively and also constructed self-harm as a behaviour that is unlikely to change. Holding such beliefs, the participants managed their anxieties by keeping face to face contact at a minimal and using ‘*doing to*’ strategies such as ‘*keeping watch*’, ‘*making deals*’ or ‘*preaching hope*’ rather than ‘*being with*’ and exploring the person’s reasoning and motives for their self-harm. However, by choosing to withhold ‘*attention*’ from clients who are *in need of* rather than *seeking*; they may add to the client’s distress, which in turn may cause the client to engage in self-harm or suicidal behaviour. Their negative and pessimistic view of these clients is also a direct contradiction to the recovery philosophy, which underpins Irish mental health policy, *A Vision for Change* (DoHC 2006). One of the core values underpinning recovery is hope including professional hope, indeed Higgins & McGowan (2014, p.68) writing about recovery in Ireland comment on the impact of professionals’ prognostic pessimism on clients and families and call on “practitioners to recast the

professional narrative to a more empowering and hopeful narrative and embrace the concept of dignity of risk, and people's right to failure".

Although self-harm has received increasing attention in the nursing literature and in clinical practice over the last two decades (Thompson *et al* 2008, Mc Hale & Felton 2010), sadly much of research conducted to date focusses on the negative stereotyped attitudes about people who self-harm from both nurses' and clients' perspectives. The National Institute in Health and Clinical Excellence (NICE) Guidelines (UK) (2004, p.18) recommended that professionals "consider giving advice and instruction on self-management of superficial injuries, including providing tissue adhesive [and] harm-minimisation issues and techniques". Speaking from a service users' and carers' experience Pembroke (2007, p.6) and Shaw & Shaw (2007) argue that harm reduction or harm-minimisation "is an alternative to preventative approaches" and accept that someone may need to self-harm at a given point. Therefore in contrast, such approaches support the person to reduce the risk and the damage inherent in their self-harm. However, to date there is minimal literature or research on the challenges and anxieties that nurses encounter moving from preventative approaches to a harm-reduction or minimisation approach. Furthermore, despite the repeated recommendations for greater education to assist nurses at both undergraduate and post registration level together with more adequate support for example clinical supervision, little information or training is available, which enables nurses to understand and respond more skilfully, positively and effectively to people who self-harm. In this study however, only a small number of participants acknowledged that they felt unskilled and unsure when working with clients who self-harm and it was this feeling of incompetence that was the '*turning point*' that motivated them to '*pursue education in a psychotherapeutic model*'. Notwithstanding this, it is difficult to determine whether the strategies of '*keeping watch*' and '*making deals*' with clients was also an attempt to manage their own feelings of insecurity in their clinical competence particularly in a culture wherein the expectation is that the practitioner is a knowledgeable and informed expert.

No place for grief and grieving

Death is a universal human experience and irrespective of position it is a deeply emotionally and painful event. When a loved one dies, one is left grieving the loss of

both the person and the relationship. Nursing research has identified that the death of a client by suicide can evoke a range of emotions in nurses such as; distress (Midence *et al's* 1996, Cleary *et al* 1999) distress and anger (Joyce & Wallbridge 2003), guilt (Midence *et al* 1996), fear, panic, sadness and grief (Talseth *et al* 1997, Valente & Saunders 2002). Experiencing the trauma of client suicide was a far more complex issue than losing a client through death from physical ill health, yet limited research exists on how nurses might deal with the aftermath of such a significant event. Furthermore, given the uniqueness of each person's grief reaction; it was difficult for participants to know exactly what they needed as a means of support to protect themselves both professionally and personally during the aftermath of a client suicide. Notwithstanding this, participants who had experienced the loss of a client by suicide and who were not attending clinical supervision had no forum to talk about their grief. This meant that they had no place to process their feelings, reflect on their responses and actions, and explore in a safe and supportive manner any learning that they could take forward into the future.

The lack of clinical supervision leaves practitioners without a safe reflective space (Morrissey 2008, 2015), and in this study it could be theorised that its absence conveys a very clear and powerful message to practitioners that their emotional well-being is not an organisational issue. Equally, there is a subliminal message that emotionality, grief or grieving has no place in the context of nurse client relationships, communicating to nurses that close engagement at an emotional level is not part of the nurse repertoire. Therefore as reflected in this study, not only is the impact of the client suicide on the participant minimised or indeed negated but also the nature of the therapeutic relationship and the time and energy invested in working with the suicidal client is not considered or valued. This gives nurses contradictory messages wherein the therapeutic use of self and the embodied engagement of practitioners with clients is held up as a core value underpinning mental health nursing practice, with prominent nurse theorists from Peplau (1952, 1997) and Barker (2009) emphasising the centrality of being with and journeying alongside clients. In addition, recent authors on recovery also speak of human engagement and the centrality of the person's story and life world in the process of healing and recovery (Repper & Perkins 2003, Higgins & McGowan 2014,). However, the absence of clinical supervision and indeed the lack of acknowledgement and sensitivity of senior practitioners to staffs' own emotional pain and angst send a clear

message that emotionality does not have a place in nursing, or indeed that it is a necessary part of grieving following a client suicide.

While self-care is something that we regularly advocate and encourage, it is often overlooked or compromised when confronted with the daily demands of our professional/working and personal life (Reeves 2010). The concept of self-care has received increasing attention and discussion in the psychotherapeutic literature yet in other helping disciplines for example nursing, it has received little attention (Evans *et al* 2008). Self-care is essential for both the practitioners' on-going professional and personal well-being and is an integral component for their work and professional identity. However, self-care is not a one-off event; it is on-going purposeful activity that is important throughout the person's working life and particularly during times of excessive stress when the workload is demanding either in terms of its volume and/or its emotional demands, such as the loss of a client through suicide (Turp 2003). In this study, the participants' emotional and physical well-being and professional development was hindered by the lack of clinical supervision alongside their anxieties and need to safeguard themselves professionally and personally during the aftermath of a client suicide. While the ritual of debriefing did take place for some practitioners, in some instances it was experienced as defensive and non-supportive and consequently heightened the participants' learning of the need to protect self by censoring any concerns and anxieties concerning their clinical experiences when working with the suicidal client. The practice of providing such forums of offering support could be characterised as a ritualistic practice (Menzies 1988) to defend and protect the organisation as opposed to a caring and supporting strategy that acknowledges the sometimes painful outcomes of therapeutic engagement and conveys a message of compassion and care for staff.

In the absence of having a supportive place to think about and process their grief and grief responses the participants were left to carry the burden of grief and *sooth* themselves with the support of family and colleagues. Paradoxically, it could be theorised that the practitioners were exposed to a different form of professional and personal danger that is the emotional cost of caring also referred to as compassion fatigue (Figley 1995). Holding on to such beliefs about grief and grieving following a client suicide it is likely that this experience will further reinforce the script of learning anxiety, which will then be subsequently passed on to others such as newly

qualified mental health nurses and learners. Such beliefs reinforce the participants' need to manage their anxieties by implementing defensive strategies in order to keep clients and self safe. Consequently, it is a reasonable strategy for practitioners to be cautious and furthermore knowing that a client suicide might recur in the future they may decide consciously and unconsciously to protect themselves by distancing from actively engaging in the therapeutic relationship. Indeed, with little or no support systems available, practitioners are likely to have difficulty in offering emotional and psychological support and/or in feeling contained themselves when working with people who present with suicidal and self-harming behaviours. This in turn, is likely to reduce the quality and efficacy of their clinical practice and as such have a negative effect for co-workers and the organisation. In the absence of clinical supervision the participants were unable to learn from the experience since they had no forum to reflect on their practice in a non-judging way and reflect on the rationales for any of their decisions made with respect to the deceased client. Dyregrov *et al* (2012) argue that the views of the individual on both suicide and bereavement are inextricably connected with the views of society. In this study, it could be theorised that although attitudes towards suicide have changed with time, the enormity of the pain and loss of death by suicide is so unbearable that it cannot be articulated and processed, and as such it reinforces the taboo of suicide and feelings of professional failure.

Education and learning

Although several writers address the need for additional education for nurses to work more effectively with the suicidal client, the issue is not whether nurses need further education but as Cutcliffe and Stevenson (2007) point out what is the nature of the additional education? Both undergraduate and post graduate nurse curricula and the vast majority of mental health textbooks associated with such nursing programmes commonly make reference to suicide. In '*Attenuating Anxieties*', it is clear that the participants are learning about strategies like observations, contracts and hope and the importance of these strategies when caring for the suicidal person. However, these strategies appear to be taught or learnt in a reductionist and dehumanising manner and veiled in a message of anxiety and protectionism. Furthermore, in the absence of an overarching theoretical framework the strategies are not positioned in context and in an integrated manner. In addition, such strategies perpetuate defensive

practice interventions and keep therapeutic engagement and empathy at a distance as well as negate the lack of evidence concerning their effectiveness from both nurses and clients' perspectives (Cutcliffe & Stevenson 2007). For example '*preaching hope*' was believed as critical when working with the suicidal person, yet as a strategy the practitioner used it in a simplistic manner and as such 'used' it in a manner that can be counter therapeutic. Indeed, not only did the participants fail to recognise that preaching and enabling hope are two very different constructs, they were also unaware that hope and belief in peoples' capacity to recover is central to the practitioner's way of being with the client (Barker 2000).

While the practice of mental health nursing has and continues to be strongly influenced by psychiatric discourse (Crowe 2004); the main tenet of mental health nursing remains that of the therapeutic relationship, in which interpersonal skills are used to develop, sustain and end therapeutic encounters in a caring, competent and compassionate manner (Morrissey & Callaghan 2011). Furthermore, this involves putting clients at the centre of nursing care (Barker 2003, Buchanan-Barker & Barker 2005). However, the relationship between the client and practitioner does not just happen or indeed should be taken as a given. Instead, it is built with care over time and based on certain core values, which are essential especially if the nurse wants to engage in a positive, supportive and therapeutic relationship. In this study, although the participants worked hard to engage with suicidal clients they struggled with the uncertainty and unpredictability of their behaviour and the anxieties this provoked in '*not knowing*' whether they could protect the clients and themselves. Working from a '*not knowing*' stance is essential to a person-centred approach to nursing care (Buchanan-Barker & Barker 2004, Rogers 1965). It is a core element of the therapeutic relationship and creates a potential space for the facilitation of clients to tell their stories with a view to enabling them to begin and/or continue their individual journey to recovery. In addition, engaging from a '*not knowing*' stance opens a space for a conversation and curiosity about the client's suicidal thoughts and behaviours so that new meanings and greater understanding can emerge for both the client and practitioner (Stevenson 2003, Reeves 2010). However, as well as consistently demonstrating respect and empathy, working from this stance involves a tolerance of '*not-knowing*' and the practitioner's ability to hold the emotional distress or '*psychache*' (Shneidman 1998) of clients. However, in this study only those participants who had pursued further training and engaged in clinical

supervision were aware of the challenges and opportunities between knowledge, knowing and '*not knowing*' (Warne & McAndrew 2007) while working with the suicidal client. For these participants, being able to '*hang their fear on theory*', reflect on their anxieties and responses enabled them to be able to listen and '*take therapeutic risks*' with the client. By being present they were then able to meet the needs of the suicidal person and help him/her to become more emotionally secure within themselves, and at the same time invite the person to talk about their experiences of moving from a death to a life orientation, and overcome their suicidality at that moment in time (Gordon *et al* 2011).

In contrast, and in the absence of clinical supervision, several participants did not engage in a collaborative dialogue related to suicide or self-harm and instead paid minimal or no attention to the private intrapersonal world of the person's lived experience. By not being curious to know more about the client and how he/she constructs meaning to their suicidal thoughts and behaviours; they limited their knowledge and *knowing* of the client's experience and paradoxically, they consciously or unconsciously placed themselves in a '*not-knowing*' position of the client's risk of suicidality at that time. Without doubt, there is the need for nurses to learn about the use of interpersonal skills, which focus more on the exploration of suicide risk and less on those that are routinely used as a ritual part of undertaking a suicide risk assessment. Notwithstanding this, the participants in this study had obtained an extensive range of academic qualifications related to mental health nursing, yet, it is difficult to identify whether if at all, their education contributed to advancing their clinical skills and competence to think critically and engage creatively when working with the suicidal person. Clearly, there appears to be a gap in terms of what is being delivered in post-registration courses concerning the knowledge and skills when working with the suicidal person. Alternatively, practitioners may consider the use of collaborative positive risk taking skills as part of the nursing academic discourse. However, it may be that such practices are not encouraged or supported by the organization wherein the primary task is to implement risk averse strategies so that they keep suicidal clients and self safe. For those participants who might want to advance towards a positive risk taking approach they may feel emotionally unsupported, unskilled or insufficiently informed about what constitutes positive risk taking strategies. In the absence of clinical supervision, they may be unprepared to implement them when working the

suicidal client. Given the uniqueness of each client's suicidal experience and recovery, to delineate specific skills as if '*one size fits all*' is the antithesis of working from a person-centred approach. Notwithstanding this, it is essential for practitioners to have a safe and supportive space wherein they can feel supported and learn to work with their anxiety as they advance their skills and confidence in therapeutic risk taking with the suicidal person. Failure to provide such continuous support and learning may result in practitioners continuing to practice *familiar risk aversive* strategies.

Although few participants used screening tools as part of their risk assessment, they were aware of the quest for screening tools and the one tool that will provide certainty and assurity. Notwithstanding the potential value of risk assessment tools, it is essential that practitioners are cognizant of the importance of paying attention to the validity and indeed copyright of such tools. In addition, if practitioners decide to use specific risk-assessment they need to be aware that they cannot '*pick-and-mix*' components of risk assessment tools, which in fact can be counterproductive and more importantly that they should be used as an adjunct as opposed to a replacement of good use of interpersonal and engagement skills.

In this study, practitioners continue to cling to the familiarity of defensive ritualistic practices of risk management when working with the person. A change in mind set is required if practitioners are to move from a risk aversion to positive taking stance. This also requires practitioners to re-examine their roles as primarily 'guardians' who constantly '*keep watch*' of people at risk of suicide. Instead, practitioners need to place more emphasis on fulfilling their espoused therapeutic role and emphasis on caring by responding as opposed to reacting to the client's *psychache* and the anxiety it engenders for them as practitioners. For practitioners to be successful in negotiating and facilitating client safety and positive risk-taking they need to be supported as they endeavour to develop meaningful relationships with suicidal clients and in so doing they can then experience a reduction rather than elimination of their anxiety. Furthermore, they can also begin to be less burdened and work from a stance wherein they are more concerned about *being with* and *responsible to* as opposed to *doing to* and feeling *responsible for* the suicidal client.

As accountable and responsible professionals and discussed earlier in the chapter, practitioners engaged in mental health care need to increase their knowledge and understanding of issues relating to clients who engage in self-harm. This means that practitioners have a professional responsibility to recognize their own prejudices and understand the impact of their prejudices on clients so that begin to learn how to relate to clients and in doing so take the necessary action to address the concerns and needs experienced by those who people who self-harm in their care (Pembroke 1996, Inkle 2010a, Shaw & Shaw 2007).

Limitations of the study

As with any study, this study has some limitations. Within the study, there are several contextual issues that need to be considered, which may have impacted on the theory generated. These include the following:

- This study was conducted at one location within one mental health service in the Republic of Ireland. The grounded theory therefore reflects the experiences of this specific population. It is therefore possible that some experiences may not apply or fit with other populations in other mental health services at different geographical locations. However, as stated some of the findings are reflected in other studies carried out outside of Ireland.
- The inductive-deductive analysis was grounded in mental health nurses' perspectives; therefore the theory generated is limited to their perspective of suicide and suicidality in relation to people with mental health distress. Mental health nurses who have been socialised or educated differently in relation to suicidality may have different perspectives and behave differently.
- A retrospective view of the participants' experiences was collected, which relied on the participants' recall of clinical practice and experiences. In the context of memory recall; the participants' accounts of clinical incidents relating to suicide and suicidal behaviour may have been influenced by recall bias such as, accuracy or completeness.
- Given the sensitive nature of the research topic area, the participants' may have consciously or unconsciously censored their accounts of clinical incidents relating to suicide and suicidal behaviour as a means of self-protection, which may have influenced the accuracy and completeness of the data.

- The use of interview data meant that the findings are reported behaviours; therefore the data is limited in that it is impossible to determine whether the participants' behaviour is the same and/or different in their actual clinical, and in addition if clients also behave the same or differently.
- The impact of the researcher's role, presence and skill is likely to have impacted on the participants' narratives and may have facilitated the participants to feel safe, comfortable and contained to share information willingly. Alternatively, it may have inhibited the participants' disclosure for fear of how they might be understood and perceived as mental health nurses.
- In grounded theory the matrix style of data analyses wherein data is fractured and conceptualised means that the whole picture is not represented because examples of participants' views are abandoned, if not supported in subsequent interviews.

Implications and recommendations

Based on a review of the literature, this is the first study to explore how mental health nurses respond to clients with suicide behaviour. The emergent theory, which was conceptualised as '*Attenuating Anxieties*' identified several important aspects of participants' views in relation to suicidality, which has a number of implications for education, clinical practice, management and research. These implications and recommendations for action will be discussed in this section. The findings in this study revealed how the participants dealt with their need to protect clients and themselves and the various strategies they used to allay their anxieties when working with clients who presented with suicidal behaviour. The theory is a complex interconnected process that is non-linear and unique to each individual and influenced by a number of critical junctures in the '*Attenuating Anxieties*' process. These include the participants' entrance to nurse education and exposure to discourses on sociology and clinical practice, exposure to caring for suicidal clients post qualifying as a mental health nurse, deciding to undertake training in a psychotherapeutic approach and experiencing the trauma of losing a client and or family member and loved one through suicide.

Implications and recommendations for nurse education and educators

It is recommended that nurse educators at undergraduate and post graduate level review current curricula to ensure that:

- They are based on a person-centred and collaborative ethos of care and reflect a more positive and therapeutic risk-taking narrative of nursing practice.
- Nurses receive education and training on how to work with and respond to clients with suicidal behaviour in a competent, creative and compassionate manner, including the knowledge, skills and attitudes necessary for nurses to respond in a more therapeutic manner to clients who self-harm.
- Emphasis is placed in students' awareness of the importance of therapeutic engagement within nursing practice.
- Nurses become aware of and develop an understanding of the importance of exploring the unique function of self-harm with clients.
- Teaching approaches adopted comprise a mixture of learning formats, with an emphasis on experiential, reflexive and interactive learning.
- Nurses increase and develop confidence and competence in assessing, exploring and working with the person during a suicidal crisis.

Implications and recommendations for management and organisation

It is recommended that managers:

- Provide protected time to attend a model of clinical supervision wherein nurses will have a regular '*supportive thinking space*' to reflect on and learn from their use of '*keeping watch*' '*preaching hope*' '*making deals*' '*profiling believability*' and '*taking positive risk*' with suicidal clients.
- Establish and promote a culture of openness in which suicide is anticipated as a possible outcome even with excellent standards of care and wherein staff are supported and encouraged to discuss and reflect on their anxieties while '*taking therapeutic risk*' when working with suicidal clients.
- Review current policies, practices and processes concerning the ongoing emotional and psychological well-being of all those affected by client suicide.
- Develop and promote a culture and ethos of the importance of continuous professional learning and development when working with suicidal clients.

Implications and recommendations for nurses working in clinical practice

It is recommended that nurses:

- Be open to acknowledge personal beliefs, anxieties and responses towards clients' suicidal behaviour and explore how such beliefs and responses might impact on the therapeutic relationship and clients' recovery.
- Acknowledge and recognise the therapeutic benefits for clients to move away from the current emphasis on defensive practices to defensible practices.
- Acknowledge and respect the uniqueness of each client's expression of suicidal behaviour and personal recovery.
- Actively involve clients in a dialogue about their suicidal thoughts and behaviours so that care and client safety is based on a mutually agreed plan rather than '*making deals*' and '*keeping watch*'.
- Work from the premise that clients are competent to make a decision unless proven otherwise and respect and support decisions even if in conflict with professional perspectives
- Be more proactive in engaging with asking clients about their self-harming behaviours with a view to providing more hopeful and effective ways of working with person who self-harm.
- Offer clients opportunities to explore their understanding of self-harm and explore strategies and interventions that can be used to promote a more hopeful and effective way of working with the person who self-harm.
- Be more willing to explore with the client the meaning of their suicidal thoughts and behaviours.
- Demonstrate a willingness and ability to develop and remain connected with the person at risk of suicide.

Research

The theory of '*Attenuating Anxieties*' provides an understanding of the strategies used by nurses to manage their anxieties when working with suicidal clients. However, there are a number of issues that require greater exploration as reflected in the following recommendations for research.

It is recommended that:

- A study is undertaken from clients' perspectives to explore the impact of 'keeping watch', 'making deals' and 'preaching hope' on their experience of care and recovery.
- Further research is undertaken to explore in greater depth the impact of client suicide on mental health nurses' physical, psychological, social and professional well-being.
- Given the dearth of research on mental health nurses' personal and professional well-being post client suicide, a more focussed study in the format of a survey is required to provide information about their initial and on-going support needs.
- Given the gap in research, a study is required to identify the initial needs of bereaved families and carers during the aftermath of a client suicide as well as the specific training needs of staff in responding to bereaved families
- A study to test the relevance of aspects of the theory in relation to other mental health nurses throughout Ireland who have different experiences of 'learning the anxiety discourse', 'cultivating it' and 'managing anxieties'.
- A study to develop interventions that promote 'taking therapeutic risk' when working with suicidal clients, and evaluate their effectiveness from both mental health nurses' and clients' perspectives.
- The theory of 'Attenuating Anxieties' is developed further by theoretically sampling other mental health clinicians who have undertaken psychotherapeutic training and who attend clinical supervision, such as counsellors, psychotherapists, psychologists.

Demonstrating the trustworthiness of this study

All types of research are open to scrutiny by their readers, therefore researchers need to be explicit about the ways that they have maintained rigor in their qualitative studies (Spencer *et al* 2003). However, one of the many challenges for qualitative researchers is deciding upon, which criteria to be applied when making judgements over the quality of a research study (McLeod 2003). Grounded theory provides a rigorous method with systematic procedures for data collection and analysis and is also concerned with the quality of the emergent theory (Elliott 2010). There are several frameworks with different criteria for ensuring the rigour and credibility of quality research in general (Kvale 1996) and grounded theory specifically (Glaser

1998). Grounded theory has its own criteria of evaluation, which include the criteria of fit, workability, modifiability and relevance. These will be discussed in relation to the ‘*Attenuating Anxieties*’ theory in this section.

Fit

According to Glaser (1998), fit refers to the categories and concepts generated and their ability to explain the patterns and variation in the data. Decisions about fit were made throughout the research process. Grounded theory research comprises several inbuilt methodological strategies for ensuring fit, which will be discussed in terms of how I adhered to them in this study. This study was completed under the supervision of an experienced grounded theorist, which involved ongoing discussions about the analytical procedures for data collection and analysis as well as all decisions about the progression of the theory. Along with regular research supervision, I made every effort to increase my knowledge and understanding of the methodology by conducting extensive reading and attending ‘The Grounded Theory Institute’ seminars facilitated by Barney Glaser and experienced grounded theorists in New York and San Francisco.

The aim throughout the coding process was to get the best concept that conceptually fitted and reflected the data. Throughout the data analysis process, codes were continuously revised, refined and reviewed and only those that demonstrated the best ‘*fit*’ were used. Once concepts were identified they were modified, refined and verified throughout the data collection and analysis phase of the study. Using the constant comparative analysis and theoretical sampling throughout the study, categories, properties and their relationships were constantly checked to see if they patterned in the new and previously collected data.

This ensured that the categories and concepts were rooted in the data and not as a result of my preconceptions and conjecture. As outlined in chapter 5, memo writing was used throughout the course of this study to identify and record my own ideas and biases. As recommended by Glaser (1998, p.120) I also “interviewed myself” and recorded and coded my experiences and thoughts. This allowed me to use them as another source of data collection and compare them against data collection in the interviews. Identifying what I thought I knew about the substantive area helped me to

feel more confident that I was making every conscious effort to suspend my professional biases and concerns.

The importance of reflexivity in relation to rigour has received attention by several writers (Cutcliffe 2003, Dowling 2006, Freshwater 2011). Reflexivity is concerned with the researcher's awareness of his /her biases and assumptions and how it might impact on the research process and vice versa. Although Glaser (1998) does not speak of reflexivity, I endeavoured to use the methods of Grounded Theory that facilitate reflexivity. In addition to using the above strategies, in particular the constant comparative process, writing memos and consulting my academic supervisor, I also utilised other reflexive practices such as clinical supervision and discussion with colleagues working in the substantive area at different times throughout the study. This helped me to identify my own beliefs and assumptions and to talk about different aspects of the emerging theory, which further helped to crystallise my thinking skills. Practicing reflexivity in this context also involved being mindful in the moment of what was influencing my internal and external responses, while at the same time being aware of my relationship to the research topic and the participants. This also helped to bring material that was unconscious to conscious. Having the opportunity to think about, explain and examine such issues also helped to enhance my ongoing analytical awareness of self, known in this context as my reflexivity as a researcher.

Workability

According to Glaser (1978), the concept of workability refers to ability of the theory to explain the participants' main concern and how they resolve it. In the description of the theory, I have included many direct quotations from the transcripts of the interviews to highlight examples of the concepts. I do believe that the context of the theory of '*Attenuating Anxieties*' offers one interpretation of what is happening in the practice of the nurses interviewed. However, I am also aware that researchers analysing the same data might use different terminology albeit I believe it would describe a similar theory.

Modifiability

Modifiability refers to the theory's ability to respond to new and emerging concepts as they become available (Glaser 1998). The theory described here represents a detailed conceptual account of the participants' responses to clients with suicidal behaviour. Similar to any theory it is subject to modifications and as such is a presentation of their main concerns in the here and now. However, as Glaser (1998) points out the theory is not being verified as in verification studies, and thus it is never right or wrong, it just gets modified by new data to compare it to. Consequently, changes in practice and even location may provide additional data that develops the '*Attenuating Anxieties*' theory and our understanding of the participants' experiences further.

Relevance

Relevance is the final criterion of the theory's rigor or trustworthiness and relates to the practical usefulness of the theory developed. A Grounded Theory is meant to identify a main concern and explain the latent patterns of behaviours that people use to resolve that concern them. In order for the theory to have relevance it must provide people with understanding and insight into the substantive area (Glaser 1998). However, Glaser (1978) argues that grounded theorists do not have to spend time to convince others of the relevance of their focus. Grounded theory arrives at relevance because it allows core problems and process to emerge.

Once the theory was developed I presented it for comment to nurses in mental health nursing and in one-one-to consultation; feedback from nurses said they could relate to the theory. I also presented the theory at national and international conferences and at grounded theory discussions and seminars. Feedback acknowledged the theory's usefulness in describing this complex, challenging and important area of mental health nursing practice. The theory '*Attenuating Anxieties*' demonstrates the participants' main concern and the different responses they take to manage resolve their anxieties. As a theory '*Attenuating Anxieties*' provides nurses with a model, which helps them to understand their clinical practices when they responded to clients with suicidal behaviour. After the theory was fully articulated attempts were made to locate the theory within the wider literature. The theory is not only supported by the literature but also has a practical application for mental nurses.

Reflections of the study

The following reflections conclude this thesis, although they do not end my learning. Just as a grounded theory emerges as an ever evolving process rather than a finished product (Glaser & Strauss 1967): it is hoped that these reflections will provide a springboard for further ongoing personal and professional learning as a theorist, researcher and educator. Conducting this grounded theory '*Attenuating Anxieties*' has changed me in many ways both personally and professionally, and it has been a rewarding and challenging experience. Throughout the thesis I have highlighted and reflected on certain issues that I encountered and their impact on me prior and during the completion of this thesis. Similar to the participants albeit on a different journey, I have moved through different stages of learning, experienced periods of certainty and uncertainty, and consequently reacted and responded to different anxieties along the way. The following reflections will focus on issues that are particularly relevant and thought provoking for me as I conclude this thesis. Although, each issue will be presented as a separate entity, I am aware that they all share some commonalities, which I was unaware of up until now. In turn this has stimulated further thoughts about my beliefs and values that inform and shape my practice in the respective roles.

Reflections as a theorist

While completing this thesis, I have examined and considered the many overlapping and often complex aspects of suicide, which has provided me with a broader understanding of the various discourses that shape and inform our understanding of suicidology. In addition, it has also highlighted the wide ranging challenges that it presents for society in general and mental health nursing in particular. Examining the different discourses has prompted me to identify my own prejudices and preferences towards certain theoretical perspectives. Drawing on my mental health nursing and psychotherapy training and experience, I use a psychodynamic lens, which focuses on a relational model to understand the suicidal client and the nature of the therapeutic relationship. While I respect that there are many discourses and each provides a different lens, I am often frustrated with the increasing emphasis and recognition given to the epidemiological discourse. Although it yields interesting and relevant data, it negates the uniqueness of what it means to be suicidal and it promotes a reductionist view of suicide. I also believe that it stifles clinicians

including mental health nurses' curiosity to move beyond asking suicide risk questions and instead engage in a dialogue wherein they explore what being suicide means for the person at that time and what he/she might find helpful to keep on living.

Reflections as a researcher

Conducting this grounded theory study has taught me many things about the process of interviewing as highlighted in earlier chapters; however, one of the most important things it has highlighted to me is the importance of engagement with the research participants. As mentioned previously, prior to conducting this research study I had not fully appreciated the parallels between the process of therapeutic engagement and engagement with research participants. Notwithstanding this, I did not view the researcher-participant relationship as a reciprocal relationship. Interestingly at the time, I felt that I was the one gaining from the research relationship and interview; consequently I felt '*indebted*' to the participants and was anxious not to '*smash and grab*' the data. Not surprisingly, I felt a sense of discomfort ending some interviews wherein the participants trusted me to share some of their challenging and emotional clinical incidents with me. Although unaware of it at the time, my sense of discomfort concerned what I perceived as an imbalance between '*what I received and what the participants gave*'. Although this requires further thought and refinement I now wonder whether the question on the university ethics form which asked about 'possible benefits (monetary or otherwise) for the participants' might have sowed the seed for my belief system. I recognise that this needs further thought and refinement. Nonetheless, I am bemused that I negated the potential benefits and value of the skill of being present and listening to the participants' narratives, especially as I espouse the same message when discussing the nurse client therapeutic relationship with students.

Without doubt, having conducted this research study has increased my knowledge and research interviewing skills. Moreover, it has highlighted the complexity of conducting interviews, particularly concerning a sensitive and emotive topic such as suicide. This has subsequently taught me about the importance of the researcher's preparedness and support both before and during data collection. However, I am aware that many nurse researchers at various levels of nurse training conduct research interviewing paying minimal if any, attention to the importance of preparing

and learning how to conduct the interview safely. Similar to the therapeutic relationship, I believe researchers need to be constantly mindful and respectful of the person being interviewed and what he/she might experience being asked specific questions about their beliefs and clinical practice.

I am mindful that when disseminating the theory '*Attenuating Anxieties*', participants might experience my construction of their main concerns while working with suicidal clients and how they resolve it as informative and supportive. Alternatively, it may be viewed and received as critical and blaming. While it is certainly not my intention to blame or criticise their clinical practice, instead, I hope the theory might provide the participants with a different understanding about what makes them respond in certain ways to suicidal clients. However, I am aware that the theory '*Attenuating Anxieties*' might evoke for some participants the need to *defend* their responses in clinical practice. Nonetheless, I am also mindful that I too need to *defend* without being defensive the theory '*Attenuating Anxieties*'. This is something I need to consider before presenting the theory. I also need to explore how I might encourage an open dialogue wherein the participants can begin to explore how their anxieties motivate their clinical responses and the impact of this for both the clients and themselves.

Reflections as a nurse educator

Having a greater understanding of the participants' anxieties and how it impacts on their clinical practice has prompted me to question what role I might play as a nurse educator in reinforcing such fears in the classroom. Interestingly, the defensive part of me wants to '*point the finger*' to the clinical area wherein '*students learn such bad practices*'. Parallel to the participants', I recognise how I might partake in the process of *splitting* – nurse education /theory (good) versus clinical practice (bad). Whilst I might espouse the practice of positive risk-taking when working with suicidal clients at risk; I question how of if I translate this in the classroom and the mental health nursing curriculum. Asking oneself what risks I take in the classroom is not an easy question to answer – how and what do I constitute as an educational risk? With some discomfort, I recognise and question whether I have avoided taking the *risk* of teaching an approach or way of working with suicidal clients that involves positive risk taking because it might be perceived as contravening the dominant model of practice in the clinical area, and indeed, some might even challenge or criticise me for teaching *unsafe* practice. Consequently, similar to the participants, I

protect my professional self by complying and in a way colluding with the discourse of risk aversion. Having a greater awareness of my '*defensive*' practice helps me to empathise with the participants but more importantly it highlights the systemic nature of risk-aversion that is perpetuated in nurse education and society.

Conducting this study has much to my amazement heightened my awareness about the denial of the reality of losing a client by suicide and the traumatic impact it has on those connected with the client including mental health nurses. Perhaps, nurse educators like others are so caught up in the suicide prevention discourse that they are blinkered in acknowledging the need to support and prepare students for the likelihood of client suicide. Ironically, I started this thesis recalling my own experience of client suicide and the informal strategies I used to cope and move on from the trauma of a client suicide. Sadly, nearly three decades later it would seem that little has changed in nurse education in this area. As a nurse educator, I recognise that I can do something by bringing it to the attention of my mental health colleagues and the curriculum group.

Finally, the theory '*Attenuating Anxieties*' illustrates the importance of being able to engage with clients expressing suicidal behaviour is paramount. However, this requires the ability to *being present* with the client as opposed to a *doing to* the client. As a nurse educator in the area of interpersonal skills, I work hard to incorporate this into my teaching with students qualified and unqualified. However, I often question whether '*interpersonal / communication*' theory/ skills is often perceived as an appendix to the curriculum rather than it being integrated into every module or component of nurse education.

Summary and conclusion

This concluding chapter presented some of the key issues that emerged from the theory '*Attenuating Anxieties*' and the literature on anxiety, risk and other literature on the substantive area that were of significance. The theory '*Attenuating Anxieties*' identifies how the participants worked within the context of mental health as members of the '*risk society*' wherein they worried about the possibility and probability of a negative or adverse effect for both the client and self, leaving them to feel constantly vulnerable and unsafe. Feeling pressured by a culture of certainty and the need to prevent client suicide and at the same time trying to keep themselves

professionally safe; they worked hard to fulfil their primary task and allay their anxieties by utilising historically known strategies to care for the suicidal person. Such practices were not only restrictive in terms of the client's freedom but also in terms of how they promoted a practice that valued the importance of therapeutic engagement and emotionality beyond the rhetoric. However, while defensive techniques formed the dominant mode of practice they also allayed practitioners' and the organisations' anxieties by promoting the illusion that such practices provided a sense of knowing and certainty when working with clients at risk of suicide. For clients who engaged in self-harm they continued to experience the negative effect of being cared for by practitioners who knew little about or demonstrated an interest in discovering the meaning and function of self-harm, beyond that of the client's behaviour. In parallel to this, practitioners also experienced a professional discourse wherein the impact of client suicide beyond that of anxiety continues to remain secretive and unspoken. Nonetheless, the acquisition of further psychotherapeutic training, clinical supervision as well as increased reflexivity and belief in professional self protected some participants. This in turn enabled them to feel more informed and thereby more contained to work creatively and collaboratively while supporting and facilitating therapeutic risk taking. Acknowledging the limitations of the study and in order to move from a position of risk aversion to positive risk taking, various recommendations are identified that need to be implemented by nurse educators, nurses working in clinical practice and by management and the organisation. The penultimate part of the chapter involved a discussion on trustworthiness as it relates to the theory and included a reflective account of specific areas of personal and professional learning during the course of the thesis. Although the issues discussed in the reflective account are by no means an exhaustive list, they reflect specific issues that have had and no doubt will continue to impact on my roles as a theorist, educator and researcher. Like all *long-distant* journeys, I am relieved to have arrived at my destination and I look forward to sharing my experience and the theory of '*Attenuating Anxieties*' with the participants and nursing colleagues.

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Appendices

Appendix 1 - Letter to Director of Nursing and Core Management Team

Date

Address:

Title of the Study: An exploration of Psychiatric nurses' responses to clients with suicidal behaviour

Dear Sir/Madam,

My name is Jean Morrissey and I am a psychiatric nurse and a nurse lecturer at Trinity College Dublin. I am currently undertaking a research degree at Trinity College and I am very interested in understanding how psychiatric nurses' respond to clients with suicidal behaviour, particularly their views and perspective of suicide behaviour in the context of psychiatric nursing and their role as a psychiatric nurse. I am writing to you to request information as to how I can obtain ethical approval in your hospital and secondly to request your support and permission to complete this study. I am also seeking your assistance in nominating a named person(s) to act as gatekeeper(s) to the chosen sample should ethical approval be granted.

Background

Suicide and suicidal behaviour is a serious public health issue and concern among mental health care professionals in Ireland. Suicide rates have almost doubled in the last two decades (National Office for Suicide Prevention 2006). Similarly, the rates of deliberate self-harm (DSH) have also increased (National Suicide Research Foundation 2007). Suicide risk is also a problem for people with mental health problems who form a considerable number of the overall presentations to both in-patient and community mental health facilities in Ireland. Psychiatric nurses are at the frontline of service provision to this client group in both hospital and community settings and have an important role to play in suicide prevention work. However, despite the potential to offer therapeutic intervention to those at risk of self-harm,

how mental health nurses should go about this is not explicitly understood (Cutcliffe & Barker 2002). There is a dearth of research in Ireland which attempts to uncover how psychiatric nurses' respond to clients with suicidal behaviour. This study will attempt to illuminate these responses and the theory generated will be used as a basis to inform clinical practice, nursing education and policy.

Procedures

The purpose of this study is to explore psychiatric nurses' responses to clients with suicidal behaviour. The study will involve interviewing Registered Psychiatric Nurses working in clinical practice in Ireland. In order to collect this data I wish to carry out interviews with Registered Psychiatric Nurses who have experience of caring for patients/clients with suicidal behaviour in in-patient and/or Community-based settings. In addition, details of a range of clinical and organisational features relating to the provision and delivery of care for clients with suicidal behaviour may be requested as part of the data collection e.g. a sample of anonymous completed risk assessment and /or nursing record sheets if theoretically relevant to the emerging theory, as well as hospital policies and protocols. One interview will be used to collect the data and this interview will take place at a time and location convenient to the participant.

I wish to ask the nominated gatekeeper(s) to distribute information packs to Registered Psychiatric Nurses who meet the inclusion criteria. If they are interested in completing the research, they will contact the researcher to arrange a suitable time and date for the interview. I have enclosed the participant information sheet.

This research will conform to the highest ethical standards and has the approval of the Faculty of Health Sciences Ethical Committee. I would be grateful if you could meet with me at your earliest convenience to discuss this proposal and to answer any queries that you may have. Please do not hesitate to contact me if you would like me to clarify any of the details outlined in this letter.

Yours sincerely,

Jean Morrissey

Appendix 2 - Letter of Invitation to Potential Participants

Date

Address:

Dear Colleague,

My name is Jean Morrissey and I am a psychiatric nurse and a nurse lecturer at the School of Nursing and Midwifery, Trinity College Dublin. I am currently undertaking a research study as part of a higher degree. Due to an increased interest in the area of suicide, my research study is focusing on the meaning of suicide behaviour in the context of psychiatric nursing care. The purpose of this study is to help develop a greater understanding of how psychiatric nurses interpret suicide behaviour and respond to health care needs in this area of practice. I have attached an information sheet, which will explain the study in more detail. The study has received ethical approval from the Faculty of Health Sciences ethics committee, Trinity College. My research supervisors are Dr. Agnes Higgins and Professor Chris Stevenson. I am writing to you to invite you to participate in this research study.

If you agree to take part in the study it will involve an interview with me at a time of your choosing. I will also arrange a venue and time that suits you. Participation is voluntary and you may withdraw from the study at any stage without obligation to anyone. I should be very grateful if you would consider being part of the study. If having read the information sheet you would like to participate in the study please contact me by phone at xxx..... or email at@tcd.ie. I should be grateful if you would let me know when it would be appropriate (day/time) to contact you. If I am not available to take your call, please leave a message and I will get back to you. Alternatively, you can complete the attached page and return it to me in the envelope enclosed. I will be in contact with you to discuss the study in more detail and clarify any further questions you might have. If following this discussion you are happy with your understanding of the study and are willing to participate we will arrange a time and venue for the interview that suits you.

If you choose not to participate I thank you for taking the time to read this letter.

Thanking you.

Yours sincerely,

Jean Morrissey

Appendix 3 - Information Sheet for Participants

TITLE OF STUDY: An exploration of Psychiatric nurses' responses to clients with suicidal behaviour.

WHAT IS THE STUDY ABOUT?

The focus of this study is on exploring how psychiatric nurses respond to clients with suicidal behaviour. The study will involve interviewing psychiatric nurses working in clinical practice in Ireland. The study has received ethical approval from the Faculty of Health Sciences ethics committee, Trinity College.

WHAT WILL YOUR PARTICIPATION INVOLVE?

If you are selected as one of the participants you will be asked to participate in an interview. The interview will consist of you speaking to me about your views and perspective of suicide behaviour in the context of psychiatric nursing and your role as a psychiatric nurse. It is important that you realise that the interview is about your understanding of suicidal behaviour and experiences of clients with suicidal behaviour from the perspective of being a psychiatric nurse. During the interview my role is to listen to your story. I will ask some open-ended questions, which you are free to answer in whatever way you choose. There are no right or wrong answers. My objective is to hear your views and opinions.

HOW OFTEN AND HOW LONG WILL YOU BE INTERVIEWED FOR?

The interview may last between 40 and 60 minutes and will be held at a time and location convenient to you and of your choosing. The interviews will be tape-recorded as it would not be possible for me to remember or write all your contribution during the interview. It is my intention to interview you once, but I should be grateful if you would give me permission to return for a second discussion should I deem it necessary as the research study unfolds.

WHAT WILL HAPPEN TO THE INFORMATION ONCE COLLECTED?

Once the interview is over, the information on the tape will be transcribed onto paper so I can read it and begin the process of looking at the information for common meanings between participants. The tape recording and any subsequent printed

transcripts of the interviews will be stored in a locked cupboard. Any information transferred to a computer will be password protected. The only people who will have access to the tape-recording are my research supervisor, myself and the person who types up the tape recordings, whom will assure me of confidentiality. At no stage will your name appear on the interview tape or the transcript. Each tape recording and printed transcript will be given a number for identification purposes. I am the only person who will know who the number corresponds to and I will not divulge this to anyone.

ARE THERE ANY CONSEQUENCES IF I CHOOSE TO BE PART OF THE STUDY OR I WANT TO OPT OUT PARTWAY THROUGH THE STUDY?

There is no obligation on you to participate in the study. If you choose to participate you are free to withdraw your consent at any time without obligation to anyone. This means you can opt out before, during or after the interview. I am aware that talking and recounting clinical experiences concerning suicidal behaviour can be a sensitive issue and you may become upset, hence you can refuse to answer any question, turn the tape off, or request to stop the interview at any time.

If you wish to drop out of the study you can tell me in person at any time during the interview, or let me know by letter, email or phone. I will give you my email and phone number at the time of the interview.

WILL PEOPLE KNOW I TOOK PART IN THE STUDY?

I will not be informing anyone that you participated in the study. Information that might identify you will not be used in any presentation or publication resulting from the study. If you wish to talk to people about the study you are free to do so.

WILL EVERYTHING I SAY BE TREATED IN CONFIDENCE?

If during the interview you tell me something that gives me cause for concern as a nurse, then I am obligated to pass on this information. Should this happen, I will tell you of my intention but I must point out that I do not need your consent to pass on the information. It is a rare possibility that this may happen, but should it happen complete confidentiality with the specific issue cannot be assured. This is a requirement for all registered nurses.

WILL I BENEFIT DIRECTLY FROM PARTICIPATING?

The purpose of the research is to produce information that may, in future, influence how nurses understand the issue of suicide behaviour and address the issues of suicide behaviour with people who have experience of mental health problems. Therefore, you will not receive any direct personal benefit. No expenses will be incurred by you, as I will be interviewing you at a time and location convenient to you.

IS THE STUDY BEING FUNDED?

This study is self-funded and I am undertaking the study as part of a higher degree.

You are under no obligation to participate in this study and deciding not to participate will make no difference to your employment.

Thank you for taking time to read this leaflet, and for considering taking part in this study.

Yours Sincerely,

Jean Morrissey

Appendix 4 - Statement of Interest Response Slip

Title of the study: An exploration of Psychiatric Nurse's responses to clients with suicidal behaviour

I would like to be part of the study: Yes

You can contact me at the following address

.....

.....

.....

You can contact me at the following phone number

.....

Signature:

Appendix 5 - Biographical Questionnaire

Code number

Grade

Clinical Nurse Manager I

Clinical Nurse Manager II

Clinical Nurse Manager III

Staff Nurse

Clinical Nurse Specialist

Community Mental Health Nurse

Other (Name).....

Location of current work

Community residence

Day centre

Day hospital

Community health centre

Admission unit in general hospital

Other (Name).....

Professional Qualifications

RPN

RGN

RMHN

Academic Qualifications

Diploma in Nursing

Bachelor of Nursing (BNS)

Post graduate Diploma in Nursing

Masters in Nursing

PhD

Other

Qualifications.....

.....

.....

Any educational programme currently undertaking

(Name).....

.....

.....

Completed training

Within research site

Outside Ireland

If outside Ireland – Country.....

Service other than the research site within Ireland

Educational programme /Training – Suicidal Behaviour or issues relating to

Suicide/ Suicidal Behaviour e.g. ASSIST?

(Name).....

.....

.....

Duration:

Half a day One Day Week

Other:

Focus of Educational programme /Training

Presentation Theory Skills training

Theory and Skills

Other:.....

Duration of time since qualifying as a psychiatric nurse

0-5 years 5-10 years 10-15 years

15- 20 years over 20 years

Duration of time in current post

0-2 years 2-4 years 4-6 years

6-8 years 8-10 years over 10 years

Worked in

Research site only

Service other than research site

If worked in other service was it?

Within Ireland only

Outside Ireland only

Within and outside Ireland

Gender

Male

Female

Attending Clinical Supervision

Yes

No

Mode (Type) of Clinical Supervision

Individual (1:1)

Group

Not applicable

Thank you very much for completing this form

Jean Morrissey

Appendix 6 - Participant Consent Form

TITLE OF THE RESEARCH STUDY

An exploration of Psychiatric nurses' responses to clients with suicidal behaviour

RESEARCHER'S CONTACT DETAILS

Ms Jean Morrissey

Tel : xxx xxxxxx

E-mail: xxxxxxxxxxxx

BACKGROUND AND PROCEDURES

The purpose of this study is to explore psychiatric nurses' responses to clients with suicidal behaviour. The study will involve interviewing psychiatric nurses working in clinical practice in Ireland. Participation will involve one interview but I should be grateful if you would give me permission to return for a second discussion should I deem it necessary as the research study unfolds. The interview will last approximately one hour and with your permission will be audio-taped. The interview will consist of you speaking to me about your views and perspective of suicide behaviour in the context of psychiatric nursing and your role as a psychiatric nurse. After the interview the recording will be transcribed and analysed. The findings of this research will be written up as a report and may be submitted for publication and/or presentation at a conference.

DECLARATION

- I have read the study information sheet and this consent form.
- I have had the opportunity to ask questions and all my questions have been answered to my satisfaction.
- I give permission to be interviewed and understand that the interview will be audio taped.
- I understand that if I wish to do so, I may have access to my interview transcript.
- I freely and voluntarily agree to be part of this research study, though without prejudice to my legal and ethical rights.
- I have received a copy of this agreement and I understand that the results of this research may be published.

I understand that:

- I may decline to answer any question(s) during the interview process.
- I may request that part of the interview be erased or not used.
- I may request that the whole interview is not to be used in the study.
- I may withdraw from the study at any time, without needing to give any explanation.
- I understand that my identity and all information collected in this study will be treated as confidential, unless I disclose information that may cause harm to anyone else or raises concern that failure to disclose such information may result in harm to another person.
- I understand that the contents of the interview are to be transcribed from the tapes by an administrator onto a computer and that this person will be bound by confidentiality not to discuss or disclose any information.

PARTICIPANT'S NAME (Block Capitals):

.....

CONTACT NUMBER:

.....

PARTICIPANT'S SIGNATURE:

.....

Date:.....

Statement of investigators responsibility: I have explained the nature and purpose of this study to the persons named above, the procedures to be undertaken and any risks that may be involved. I have offered to answer any questions and have fully answered such questions. I believe that the person named above understood my explanation and have freely given informed consent.

Investigator's Signature:

Date:.....

For Investigator's Use Only

Participant

Code:

Appendix 7 - ASIST - Course Outline

ASIST (Applied Suicide Intervention Skills Training) is an internationally recognised skills awareness programme in suicide prevention. It is a two day intensive course designed for both professionals and the general public. The aim of the ASIST workshop is to help caregivers provide emergency first aid to people at risk of suicidal behavior. As an interactive workshop, participants examine their attitudes to suicide, learn how to recognize and review the risk of suicide and develop their skills through simulations and role-playing in order to become more ready, willing and able to help people at risk of suicide. This course is designed for all caregivers, which includes professionals, paraprofessionals and lay people and is suitable for mental health professionals, nurses, physicians, teachers, counsellors, youth workers, police and correctional staff, school support staff, clergy and community volunteers.

ASIST was developed in the 1980s by a team of mental health and social work professionals, in collaboration with the state governments of Alberta and California. They created Living Works Education Inc as public service cooperation in 1991. Since then, the programme has been delivered through networks of registered trainers in Canada, Australia, Norway, the United States and Europe. LivingWorks provides ASIST for prospective trainers and has responsibility for ASIST quality control in Ireland. The HSE National Office Suicide Prevention has an agreement with LivingWorks in Canada who own the franchise and copyright, to provide the programme in Ireland. The HSE NOSP (National Office of Suicide Prevention) coordinates the delivery of ASIST and Safetalk through 12 coordinating sites around the country.

Learning content

- To recognise that caregivers and persons at risk are affected by personal and societal attitudes about suicide.
- To learn how to discuss suicide with a person at risk in a direct manner.
- To be able to identify risk alerts and develop safe plans related to them.
- To demonstrate the skills required to intervene when a person is at risk of suicide.
- To become familiar with the types of resources available to a person at risk of suicide, including themselves.
- To make a commitment to improving community resources.

Suicide Intervention Model

Connecting →	Understanding →	Assisting →
Invitation? Suicide? ↓	Reason? Risk? ↓	Safe plan? Commitments? ↓
Ask and Explore	Listen and Review	Contract Follow-up

Appendix 8 - Participants' Biographical Profile

Nursing Position		Place of Work	
Clinical Nurse Manager I	3	Community Mental Health Centre	11
Clinical Nurse Manager II	8	Day hospital	6
Clinical Nurse Manager III	1	Day centre	2
Staff Nurse	12	Home Care	6
Clinical Nurse Specialist	5	High Observation Ward	4
Community Mental Health Nurse	4	Admission unit in general hospital	4
Professional Qualifications		Academic Qualifications	
RPN	33	Diploma in Nursing	9
RPN & RGN	4	Diploma /PGDip in Family Therapy [2] Cognitive Behaviour Therapy [6] Dialectical Behaviour Therapy [2]	10
PN & RMNH	1	BSc - Nursing	9
		Bachelor of Science - Management	2
		Post graduate Diploma in Nursing [SEMI]	6
		MSc Nursing	5
		MSc Psychoanalytical Psychotherapy	1
		Educational programme currently undertaking	2 MSc Nurs. 1 BSc Nurs.
Length of time Qualified as a psychiatric nurse		Location of Nurse Education / Training	
0-1 year	4	Within research site	22
1-4 years	1	Service other than the research site within Ireland	1
5-10 years	9	Outside Ireland – UK [9], Nigeria [1]	10
10-15 years	8		
15- 20 years	4		
over 20 years	7		
Gender		ASSIST Training	
Female	17	Yes	12
Male	16	No	21
Attending Clinical Supervision			
Yes	7		
No	26		

Appendix 9 - Examples of Memos Post Interviewing

Interview F1

My first interview, I think it went well, not sure who was more nervous me or the participant. I was aware that the participant was nervous at the beginning; there were lots of nervous laughs from both of us. After a while we both settled into the interview; pleased I didn't react to the 'silent pauses' at the beginning – I know I sometimes can talk too much if I am nervous. Stayed with the silence, although I was afraid, if I left it too long the participant would just 'clam up'. I discovered that asking for clinical examples really helped the participant to describe what she was trying to convey - it also helped me to understand what the participant actually meant rather than assume that I understood. Didn't plan to but I caught myself using paraphrasing as a means of probing, I think it was better than questioning at this point but did wonder whether it might annoy participants? Participant identified it as useful at the end of interview. However, there were times when the participant became slightly embarrassed and uncomfortable hearing my perspective of what I heard about her attitudes towards clients who self-harm. Some might say that this was good – however, I didn't want the participant to feel that I was judging her. I am unsure how I could do this differently...? Need to think about this and discuss with supervisor. Aware of participant using an unusual word 'genuine client' – not a term I am familiar with – need to check it out / or listen for it in next interview.

Interview M3

I was a bit taken back by this interview. Participant spoke about personal experience of losing a close friend by suicide. Throughout the interview he answered the various questions while making reference to the deceased person. I checked with the participant at the outset if he was comfortable having the interview recorded. I felt uncomfortable when he first made reference to his friend. Somehow, I was afraid of being "intrusive" - not sure what that is about, but interesting. I hadn't anticipated this response. I wonder if others feel like this and as a result don't ask the person about his loss and therefore unknowingly perpetuate the stigma of suicide. Need to think about this further. I am also embarrassed – I never thought or expected participants to talk about personal experiences of suicide. This has really shocked me – was I naïve or am I in some way 'de-personalizing' the participants or was it my

unconscious protection against the pain or reality of suicide. Ironic really, - begs the question for my choice of topic! I might take this up in clinical supervision.

Interview F7

I am emotionally shattered after this interview. Interview lasted for 1 hour and a half, I listened attentively as participant described her role and involvement with two clients who died by suicide. Participant described the details of the suicide event and the time after in such detail as if she was debriefing or processing the events. It wasn't easy to listen – I am intrigued that it both suicides happened over eighteen months ago. Participant spoke about it as if it was last week. I knew I was being 'trusted' with material that had not been disclosed to other colleagues. Aware that this interview session was similar to what could be discussed in clinical supervision. However, this was a research interview and whilst I would 'take away' the recording of the interview – I wondered whether the participant hoped I could take away the 'unspoken' – perceived sense of shame and pain of losing a client by suicide. I find it interesting that participant found it difficult to be angry toward clients for not telling her or others about their intentions. It's like you can't angry with dead. Left wondering what the emotional impact has been on this participant – 'holding onto these feelings post client suicide' – must check this out with other participants.

Appendix 10 - Memos – Grounded Theory Institute Seminar - New York

Memo Oct 2008

Day One

I was nervous and excited attending today – colleagues said the seminars are very relaxed, yet very useful and informative I hope so! Surprised to see so many people from different geographical areas and areas of work selecting GT to undertake their research. Good to hear people's experiences outside of nursing. Barney started off this talk by giving a historical background to his theory followed by a presentation about the importance of remaining open. Whilst I had understand this theoretically, it was only by listening to other participants and being questioned by Barney and others that I learnt that this wasn't always as easy as one imagined. It was great to hear from Barney, he presented the main principles of his approach - which was good as it helped me to get to grips with some of his ideas and principles, for example, theoretical sampling. I know I learn best by hearing things over and over again before I can truly understand how it is applied to my study. I really like the way they run this seminar – there are so many experienced people who can offer a different perspective, which is good although at times I found some parts 'over my head'. Many participants were novices to Grounded Theory which was comforting – others were nearly finished and writing up their study. People clearly were at different stages of learning and their research study – I am just starting to collect and analyze data. Presenting tomorrow – I have chosen to present some initial coding – hope to get some feedback that I am on the right track. Not sure if I fully understand what Glaser meant when he said if it's not in the data it won't emerge?

Day Two

Took a risk and gave the GT mentors a copy of my initial coding for feedback and possible ideas. Received very encouraging feedback about my coding – pleased to know that I am doing that okay. Of course one question prompts another question – just when you think you have 'got it' – something else is triggered. Beginning to 'get it' regarding variables having to work their way into the data – well I hope I am! Regarding the context of my research study – i.e. community and in-patient services, I have been struggling trying to keep these separate, when in fact they are just the background in relation to the participants' main concern and how they resolve their

concern. That has taken me some time to grasp that – I was ‘forcing’ the data between community and in in-patient. As a result I got into comparing the differences rather than seeing the similarities, for example, observing clients happens in both contexts, it is just carried out differently and by different people. I can’t describe the pure sense of joy and relief after this ‘break through’. It was a real aha moment!

Appendix 11 - Memos – Grounded Theory Institute Seminar – Mill Valley, San Francisco

Day One

Unfortunately I can't take many notes after my accident. Still I can listen, good practice so all is not lost! One person presented today and it was fascinating – she had what Glaser calls a 'pet subject'- as a result, she struggled with identifying what the participants considered as their main concern' - it was more about her main concern. I felt for her – because she was so passionate about her topic area but that was the issue it was her 'pet topic' and the more she talked about it – the clearer it became for me that this is what Glaser referred to in his book – Doing Grounded Theory Issues and Discussions. The fact that I understood this helped me to clarify and affirm my learning of GT to date. Still more to learn.

Presented my theory, whilst I am clear about the participants' main concern – keeping clients and themselves safe – I am struggling with how they resolve it. Issues about anxieties and uncertainty but need to give it more thought. Suggestion by Otis re the participants' fate is tied with the clients – this fits with their need to keep clients and themselves safe. Need to develop this further - I wonder what feelings that might evoke consciously or unconsciously for participants? Need to go back to participants and ask questions about this and see where it might take me or not.

Appendix 12 - Theoretical Memo

Example of an early memo on the concept of ‘*making deals*’

Concept: ‘**Making Deals**’

1st interview [Date]

This person used the words ‘no-suicide contract’ to describe an intervention used with clients when they were considered to be suicidal. Designed by the person as a written form with no direction or guidance from the literature or hospital policy. There is a sense from this person that ‘suicide contract’ are initiated in response to their concern at a particular about the client’s safety and subsequently implemented in a prescriptive manner. Copy of contract given to client and kept by the nurse, although interestingly not always placed in client’s nursing notes. This person has no recollection of where they learnt about ‘no-suicide contract’.

2nd interview [Date]

Again there is a sense that the nurse initiates a no-suicide contract in response to concerns about client safety; however, this person is critical of the term ‘no-suicide contract’ and instead describes the intervention as a verbal ‘promise’. Although the verbal promise and written contract contain similar components such as, what the client will or will not do when suicidal – there is a sense that this person views them as two different interventions. There is also a sense of a Parent-Child interaction – in that the ‘promise’ is accessed *from* the client.

3rd interview [Date]

This nurse is aware of the use of ‘no-suicide contracts’ and verbal promises and is sceptical of their therapeutic value in keeping clients safe. Again there is a sense from this nurse that they are implemented by nurses as a ‘*safety valve*’ for themselves in case of a client suicide. Interestingly, this person refers to having ‘an agreement’ with clients as a means of assisting them to stay safe. Viewed as different from ‘no-suicide contract’ or making a ‘promise’; there is also a sense that agreements between the client and nurse are negotiated and considered based on the nurse-client relationship. From these three interviews it appears that agreements under various terms are initiated by nurses in response to the potential risk of client suicide. As an nursing intervention, they serve dual function of ‘*doing something*’ as a means of keeping the client safe and providing ‘evidence’ of what they did based

on what client agreed. How does this fit with other nursing interventions? Are there nurses who do not use such interventions? What happens after suicide risk – are they reviewed? There is also a sense that nurses' implement such agreements in response to their fear of client suicide. Start checking this out in subsequent interviews. Need to consider how this intervention relates or not to other interventions such as special observations.

Example of a later memo, after sorting early memos

Concept: **'Making Deals'**

Nurses consider that clients are their professional responsibility once they come into their care. For some nurses this responsibility is more akin to paternalistic responsibility as opposed to a joint relationship. They are focussing on caring for and responsibility for as opposed to caring with and responsible to. Nurses are very conscious that they have a duty of care for clients and as far as possible prevent any client from harming him/herself under their care this duty of care. This in turn gives rise to a number of concerns or possible consequences for themselves and the client; for the nurses in relation to being accused of negligence. Therefore, in order to keep the client safe and consequently keep themselves safe from being accused of negligence they operate out of a model of care that is reactive and paternalistic and is adverse to positive risk taking with clients. Their approach is one of immediacy as opposed to long-term protection. They tend to enact that protection in a reactive or driven; focus is keeping client safe and allaying their fears about the enormity and uncertainty of their task. None of this process is written and there has been no general discussion at organisation or team level, with a lack of organisational guidelines or policy. What is documented is done in a way to provide evidence of how they fulfilled their responsibility and what responsibility rests with the suicidal client. Need to consider and explore how this concept related to the concept of 'sharing responsibility'.

Appendix 13 - Ethical Approval – Clinical Site



THE UNIVERSITY OF DUBLIN

TRINITY COLLEGE

SCHOOL OF MEDICINE

FACULTY OF HEALTH SCIENCES

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Ms Jean Morrissey
Staff - School of Nursing

Friday, 22 February 2008

Study Title

An exploration of Psychiatric nurses's responses to clients with suicidal behaviour

Dear Applicant

Further to a meeting of the Faculty of Health Sciences Research Ethics Committee 2007 - 2008,
I am pleased to inform you that the above project has been approved without further audit.

Yours sincerely

Dr. Orla Sheils
Chairperson
Faculty of Health Sciences Ethics Committee

cc.
Dr Agnes Higgins: Staff - School of Nursing

Appendix 14 - University Ethical Approval

THIS NOTEPAPER MUST NOT BE USED FOR
PRESCRIPTIONS OR INVOICING PURPOSES



**THE ADELAIDE & MEATH
HOSPITAL, DUBLIN**
INCORPORATING
THE NATIONAL CHILDREN'S HOSPITAL

SJH/AMNCH Research Ethics Committee Secretariat
Dan Lynch Ph: 4142860 email: Dan.Lynch@amnch.ie
Ursula Ryan Ph: 4142342 email: Ursula.Ryan@amnch.ie
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TALLAGHT, DUBLIN 24, IRELAND
TELEPHONE +353 1 4142000

Ms. Jean Morrissey
Lecturer
School of Nursing & Midwifery
24 D'Olier Street
Dublin 2

April 22nd 2008

Re: An Exploration of Psychiatric Nurse's Responses to Clients with Suicidal Behaviour.

Please quote this reference in any follow up to this letter: 2008/03/09 Chairman's Action.

Dear Jean,

Thank you for your recent submission of the above proposal to the SJH/AMNCH Research Ethics Committee.
The Chair, having reviewed the proposal, has given ethical approval on behalf of the Committee.

Yours sincerely,

Daniel R. Lynch,
Secretary,
SJH/AMNCH Research Ethics Committee

Appendix 15 - Proposed Interview Guide

In keeping with the principles of Grounded theory (Glaser and Strauss 1967) the interview will commence with the following open question, followed by probing to elicit elaboration on specific issues concerning the topic area. As themes and categories emerge from the data, subsequent interviews will be more focused until theoretical saturation of the categories occurs.

Central Research Question

In an interested in qualified nurses' experiences of caring for clients who present with suicidal behaviour, can you tell about your experiences of caring for clients who present with suicidal behaviour?

ProbingCan they give the most recent example of when this happened?

Theoretical Questions

- What is your understanding of suicidal behaviour?
- How do you make sense of a person (client/service user) attempting to harm him/herself?
- What's the first thing you think of when you are caring for a client who presents with suicidal behaviour?
- How do feel when you are with the client?
- What guides your actions (practice) when caring for clients who present with suicidal behaviour
 - Professionally?
 - Ethically?
 - Legally?
- What do you think your role is in relation to caring for clients who present with suicidal behaviour?
- What conflicts (personal and/or professional) have you experienced when caring for clients who present with suicidal behaviour?
- How have you managed these conflicts?
- What criteria do you use to assess if a client is suicidal?
- How do you discuss the issue of suicide/suicidal behaviour with a client?

- How and where do you record this information?
- Who do you think is responsible for a client who presents with suicidal behaviour?
- What specific training/education have you received in relation to caring for clients with suicidal behaviour?
- How useful was it?
- How do you measure your therapeutic effectiveness when caring for clients who present with suicidal behaviour?
- What opportunities have you to discuss your concerns about a client who is presenting with suicidal behaviour?
- How did or do they assist (or not) you?

Appendix 16 - University Ethical Recommendations

No	Name	Study Title	Decision
2	Ms Jean Morrissey	An exploration of Psychiatric nurses' responses to clients with suicidal behaviour	<p>You must address EACH of the issues below and amend your application accordingly. Please send response to louise.whehan@tcd.ie and ensure that ALL amendments to the form and appendices are highlighted by either changing the colour of the text or using the tracked changed facility in WORD:</p> <p>***YOUR APPLICATION WILL NOT BE FURTHER CONSIDERED UNLESS THE ABOVE INSTRUCTIONS ARE FOLLOWED***</p> <p>-Please provide the interview schedule. -Please identify the hospital/healthcare facilities where the research will be conducted (2.3/2.6) -Participants names should not be used in any <u>draft</u> of the report, as well as the final report (3.7). Please amend.</p>

Dr Agnes Higgins

Appendix 17 - ROVA Assessment

RISK OF VIOLENCE AND SELF HARM ASSESSMENT (ROVA) - 2

Section 2: RISK OF SELF HARM OR SUICIDE
 Document your **CLINICAL JUDGEMENT (CJ)** of patient's presentation. Refer to chart entries where appropriate.

Section 2a: LIFESTYLE

Name: _____ Age: _____ Gender: _____ Ethnicity: _____ Sexuality: _____

Living situation: social supports / social isolation / homelessness: YES NO

CJ: _____

Family / partner / carer: YES NO UNKNOWN

CJ: _____

Recent work / role change in life: YES NO

CJ: _____

Recent loss: YES NO

CJ: _____

Section 2b: BEHAVIOUR

History / current thoughts / plans of self-harm / suicide: YES NO UNKNOWN

CJ: _____

History / current attempt of self-harm / suicide: YES NO UNKNOWN

CJ: _____

History / current Use of violent method/s: YES NO UNKNOWN

CJ: _____

Alcohol / drug dependence / abuse (including prescription meds): YES NO UNKNOWN

CJ: _____

Depressed mood: YES NO

CJ: _____

Poor self-esteem / guilt / hopelessness / worthlessness: YES NO

CJ: _____

Changes in sleep / appetite / libido / energy / motivation: YES NO

CJ: _____

Section 2c: OTHER RISK FACTORS

Diagnosis of psychiatric illness: YES NO

CJ: _____

Delusions or paranoid behaviour that may result in harm to self: YES NO

CJ: _____

Measures taken to ensure suicide or self-harm is/is not detected: YES NO

CJ: _____

Family history of suicide: YES NO UNKNOWN

CJ: _____

History of abuse: YES NO UNKNOWN

CJ: _____

Overall Clinical Judgement (CJ) of RISK OF SUICIDE or SELF-HARM 0= Nil Risk 1= Low Risk 2= Moderate Risk 3= High Risk	<input type="checkbox"/>	Review Dates Indicate in chart when review completed. Refer to chart entries where appropriate.	Risk of Suicide or Self-harm Management Plan Necessary: YES <input type="checkbox"/> NO <input type="checkbox"/>
			Location of Management Plan in Chart: _____

Date of assessment: _____	Completed by: Print name(s): _____ Signature: _____ Designation: _____	Place of assessment: _____ Collateral information source: _____
---------------------------	---------------------------------------------------------------------------------	--------------------------------------------------------------------