MONASH University

An investigation of the attitudes, behaviours and interactions of nurses in acute care settings when providing suicide attempt aftercare

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Abstract

Introduction

Many people are admitted to hospital following a suicide attempt in order to receive aftercare that facilitates the medical or surgical interventions required to enable physiological recovery. Nurses who work in these environments are not specialist mental health clinicians, but are required to deliver care to people with comorbid physical and mental health issues.

Aim

The aim of the research was to explore the factors that influence the behaviours of nurses working in acute care settings and identify their skills and knowledge in relation to working with people following a suicide attempt.

Method

A multi-modal approach of six research outputs comprised of five individual projects used both qualitative and quantitative methodology designs. Research was undertaken at a large metropolitan health service, which has multiple hospital sites in south-eastern Melbourne, Australia. The qualitative component involved the interviewing of Nurse Unit Managers, Clinical Nurse Educators and Senior Nurses who work with medical and surgical nurses who are required to provide suicide attempt aftercare. Interviews were also conducted with people admitted to hospital following a suicide attempt. The quantitative component involved the survey of Registered and Enrolled Nurses employed to work on medical and surgical wards to which consumers are admitted to hospital

following a suicide attempt. The survey, conducted either in hardcopy or electronically, explored the demographics, therapeutic optimism, attitudes to attempted suicide and defence mechanisms exhibited by these nurses.

Findings

Utilising the Theory of Planned Behavior (Ajzen, 1985) as a theoretical framework, it was established through the process of triangulation that medical and surgical nurses are inhibited in their ability to provide suicide attempt aftercare because of their experiences with suicide anxiety and the resultant defences they employ. This results in consumers not receiving the care they require to assist them during their recovery. At the same time, patients do not expect these nurses to have the knowledge and experience to support them during hospital admissions, and subsequently engage in superficial or avoidant behaviour.

Conclusion

Attitudes to suicide attempts, therapeutic optimism and defence mechanisms are all influenced by the concept of suicide anxiety. Education regarding suicide awareness and prevention is recommended for all nurses, irrespective of specialty, and should incorporate anxiety-ameliorating elements.

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Publications during enrolment

Barnfield, J., Cross, W. & McCauley, K. (2018). Senior Nurses' perspectives of nursing care following a suicide attempt. Submitted to Nursing and Health Sciences for publication.

Barnfield, J., Cross, W. & McCauley, K. (2018). Consumer perspectives of nursing care following a suicide attempt. Submitted to Nursing and Health Sciences for publication.

Barnfield, J., Cross, W. & McCauley, K. (2018). Therapeutic optimism and attitudes among medical and surgical nurses towards attempted suicide. International Journal of Mental Health Nurses. In press.

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Barnfield, J., Cross, W. & McCauley, K. (2018). An investigation of the defense styles of medical and surgical nurses when providing suicide attempt aftercare. Submitted to Journal of Psychosocial Nursing for publication.

Thesis including published works declaration

I hereby declare that this thesis contains no material which has been accepted for the award of any other degree or diploma at any university or equivalent institution and that, to the best of my knowledge and belief, this thesis contains no material previously published or written by another person, except where due reference is made in the text of the thesis.

This thesis includes *1* accepted and *3* publications submitted to peer-reviewed journals. The core theme of the thesis is suicide anxiety. The ideas, development and writing up of all the papers in the thesis were the principal responsibility of myself, the student, working within the School of Nursing & Midwifery under the supervision of *Professor Wendy Cross* and *Associate Professor Kay McCauley*.

Dr. Alex McKnight proofread the final draft for grammatical and stylistic errors.

In the case of Chapters 4 and 5 my contribution to the work involved the following:

Table 1: Publications and contributions 1

Thesis Chapter	Publication Title	Status *(published, in press, accepted or returned for revision, submitted)*	Nature and % of student contribution	Co-author name(s) Nature and % of Co-author's contribution*	Co-author(s), Monash student Y/N*
4	Senior Nurses' perspectives of nursing care following a suicide attempt	Submitted	Concept and collecting data and writing first draft (60%)	1) Professor Wendy Cross, input into design and manuscript (30%) 2) Associate Professor Kay McCauley, input into design and manuscript (10%)	No No
4	Consumer perspectives of nursing care following a suicide attempt	Submitted	Concept and collecting data and writing first draft (60%)	1) Professor Wendy Cross, input into design and manuscript (30%) 2) Associate Professor Kay McCauley, input into design and manuscript (10%)	No No
5	Therapeutic optimism and attitudes among medical and surgical nurses towards attempted suicide	In press	Concept and collecting data and writing first draft (60%)	1) Professor Wendy Cross, input into design and manuscript (30%) 2) Associate Professor Kay McCauley, input into design and manuscript (10%)	No No
5	Defense styles of medical and surgical nurses when providing suicide attempt aftercare	Submitted	Concept and collecting data and writing first draft (60%)	1) Professor Wendy Cross, input into design and manuscript (30%) 2) Associate Professor Kay McCauley, input into design and manuscript (10%)	No No

I have not renumbered sections of submitted or published papers within the thesis.

Student signature: [redacted] **Date:** 03.03.2018

The undersigned hereby certify that the above declaration correctly reflects the nature and extent of the student's and co-authors' contributions to this work. In instances where I am not the responsible author I have consulted with the responsible author to agree on the respective contributions of the authors.

Main Supervisor signature: [redacted] **Date:** 03.03.2018

Acknowledgements

There are many things one learns about oneself when undertaking a PhD. Whilst I had a moderate understanding of who I am, this experience has also taught me to accept my shortcomings and to celebrate my strengths. I won't mention my shortcomings (those of you who know me are probably well aware of them), but I must acknowledge that some of my strengths are derived from the supportive people within my life.

First and foremost, I thank my supervisors, Associate Professor Kay McCauley, who originally convinced me that undertaking a PhD was achievable and that it would be a 'we' not a 'me' experience. My main supervisor, Professor Wendy Cross, has been a mainstay within the academic arena throughout my mental health nursing career. You have taught me many things over recent years, both consciously and unconsciously, and have freely given your time and ideas. I can honestly state that without your clarity and encouragement, I would not have realized the attainment of this goal. Your joy and enthusiasm for research and nursing are contagious and motivational.

My friend and colleague, Tracey Harmer, who herself holds a position that is relentless and emotionally-charged, has always been available for a theoretical discussion, proof reading, someone to bounce ideas off and a couple of endurance events along the way.

Lastly, I would like to thank my family for all their love and encouragement. My mum, who is not shy of saying "I'm proud of you". Whilst this has become a family mantra, it is something I do not tire of hearing. My sister Reggie (Jenny) and our ethical conversations about nursing issues. Most of all my loving, supportive, encouraging and patient husband, who has also achieved a lifelong goal, while I achieved mine. This is an acknowledgement for your encouragement, support and acceptance that for a significant part of our home life,

and for more than half of Zoe's life, I have been working towards a goal that I will have achieved, but to which you have contributed. I would be remiss if I did not mention the enjoyment I derive from my afternoon walks with Zoe when we discuss philosophical topics, albeit through a child's lens, and I love the fact that she can talk about suicide with the grace of understanding rather than condemnation.

Thank you all.

What one does is what counts, not what one had the intention of doing –

Pablo Picasso

Definition of terms

Attempted suicide for the purposes of this study refers to the attempt to die at one's own hand, where a person has not died as a result and has experienced injury or harm.

Consumer refers to any person who would otherwise be afforded the title of patient. It is these people in this study who have attempted suicide.

Enrolled Nurse (EN) is an associate to the registered nurse who demonstrates competence in the provision of patient-centred care and remains accountable for providing delegated nursing care. Although the scope of practice for each EN varies according to context and education, the EN has a responsibility for ongoing self- and professional development to maintain their knowledge base through life-long learning, and continue to demonstrate the types of core nursing activities that an EN would be expected to undertake on entry to practice (NMBA, 2016b).

Registered Nurse (RN) is a nurse who demonstrates competence in the provision of nursing care as specified by registration requirements, National Board standards and codes, educational preparation, relevant legislation and the context of care. The registered nurse practices independently and interdependently, assuming accountability and responsibility for their own actions and delegation of care to enrolled nurses and health care workers (NMBA, 2016a).

Suicide for the purposes of this study refers to the intentional death by one's own hand.

Suicide attempt aftercare for the purposes of this study refers to the treatment and care required by someone who has made a suicide attempt. It also describes

the treatment and care delivered by nurses for someone who has attempted suicide.

Chapter One: Introduction

Background

Around the world over 800,000 people die as a result of suicide each year, equating to one person every 40 seconds (WHO, 2014). Australian data from 2016 indicated that 2866 people died by suicide (Australian Bureau of Statistics, 2017); that equates to nearly 8 people dying each day in Australia by their own hand. Significantly, Aboriginal and Torres Strait Islander people are over-represented in the data, with 23.8 deaths per 100,000, compared with 11.4 deaths per 100,000 for non-indigenous Australians (Australian Bureau of Statistics, 2017). A history of attempted suicide is the highest risk factor for suicide; consequently, the numbers of people attempting suicide is a matter of concern (WHO, 2014). There are estimates that incidents of attempted suicide are between 20 and 23 times greater than episodes of suicide (De Leo, Cerin, Spathonis, & Burgis, 2005; WHO, 2014), with some people attempting suicide more than once. Of those who attempt suicide and do not die, many require hospitalisation and aftercare. As a result, nurses in all sub-specialties of practice are likely to provide care for someone who has suicidal ideation or has attempted suicide, at some point in their career (Guptill, 2011; Lakeman, 2010; McCallister, Creedy, Moyle & Farrugia, 2002).

It is known that not all nurses receive education about suicide, although as previously mentioned, they may be required to provide suicide attempt aftercare. Rebair and Hulatt (2017) conducted a study in the United Kingdom in 2015 which suggested that over 60% of nurses had not received education about suicide

whilst undertaking their initial nursing qualification. In addition, 50% of respondents indicated that they had not received education regarding suicide since their registration (Rebair & Hulatt, 2017). Suicide education that incorporates assessment, intervention, negotiation and postvention skills should ideally begin at university during undergraduate programs (Hazell, Hazell & Waring, 1999). This is supported by a study recommending that nursing students should receive education about suicide and the care of a suicidal person before they commence work in the clinical area (Sun, Long, Huang & Chiang, 2011). Other nurse researchers have been advocating for the development of education standards about suicide to be developed, leading to the provision of mandatory education on this subject (Bolster, Holliday, Oneal & Shaw, 2015). The difficulty faced when educating and up-skilling health workers in the provision of adequate care to someone who is suicidal is a barrier, both from the perspectives of health care organisations, and of individual nurses. Education carries with it an implied cost investment, with requirements for study leave, additional staff resources, policy and practice changes and implications for rostering requirements. Hurdles to participation in suicide education include perceived knowledge and skills, impact on nursing care delivery time, personal resilience and resources, stigma and non-maleficence (Rebair & Hulatt, 2017).

Irrespective of the knowledge and skill levels of the clinician, difficulties still remain in equating risks with potential outcomes (Weir, 2001). Predicting the occurrence of suicide based upon completion of a risk assessment is problematic, because individuals do not live in isolation with inherent suicide risks, but are impacted by other factors. The World Health Organisation (2014) categorises these other factors for suicide risk into five elements: health systems, society,

community, relationships and individual. In addition, four precursors are identified as risk factors for suicide by the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (2016). These antecedents are: drug and alcohol misuse, economic adversity, isolation and previous attempts at self-harm.

Caring for people after they have made a suicide attempt or who have developed suicidal ideation can be a difficult and extremely frustrating experience for nurses (Anderson, 1997; Anderson, Standen & Noon, 2003; Doyle, Keogh & Morrissey, 2007; Gibb, Beautrais & Surgenor, 2010; McAllister et al, 2002; Osborne, 1989). It is not uncommon for nurses to withdraw interaction and care and provide only the necessary physical functions of the nursing role to someone who has attempted suicide (Bailey, 1994; Carlén & Bengtsson, 2007; Guptill, 2011; Main, 1989; Osborne, 1989; Simpson, 1998). The literature identifies a number of personal reasons why nurses respond to people who are suicidal in the way that they do: not knowing what to say (Bailey, 1994; Gibb et al, 2010), feeling out of their depth (McLaughlin, 1995; Perego, 1999), lack of competence (Doyle et al, 2007; McLaughlin, 1995; Valente & Saunders, 2004), anger (Gibb et al, 2010; Wilstrand, Lindgren, Gilje & Olofsson, 2007), fear (Alston & Robinson, 1992; Wilstrand et al, 2007), unsatisfying nursing experience (Bailey, 1994; Wilstrand et al, 2007), lack of empathy (Gibb et al, 2010), helplessness (Doyle et al, 2007; Johnstone, 1997; McAllister et al, 2002), self – protection (Keogh, Doyle, & Morrissey, 2007) and feeling manipulated (Vivekananda, 2000; Wilstrand et al, 2007).

Communication has long been recognised and understood as a core skill within nursing (Stein-Parbury, 2014) and an integral element within the communication process is empathy (Ferrucci, 2007). In his seminal work, Rogers (1961) explained that the notion of empathy enables people to understand another person's perspective whilst maintaining one's own outlook. It may be difficult for nurses to exhibit empathy when confronted with a suicidal person, as this implies an understanding of the person's experiences. Two essential ingredients of nursing practice, empathy and compassion, when combined provide an environment safe from judgement, criticism or abandonment that enables people to speak about their experiences (Cooper & Sawaf, 2000). It has been asserted that negative attitudes towards the person who has attempted suicide may be indicative of an inability to provide care (Keogh et al, 2007). It is important to reflect that when nurses engage in avoidance behaviours and withdraw nursing care, it may be perceived by the consumer as a form of rejection, consequently increasing their sense of isolation and aloneness (Bailey, 1994; LIFE, 2007; Osborne, 1989).

Nurses appear to be anxious about caring for a person following a suicide attempt. Many theories have been developed in an effort to understand and explain anxiety. There are biological rationalizations, psychoanalytical theories, cognitive philosophies and learned behaviours (Rachman, 2004). According to Rachman (2004), biological rationalizations attempt to explain primarily the disorders associated with anxiety: anxiety disorders, panic attacks and obsessional-compulsive disorders. Psychoanalytical theories consider anxiety to be a rational fear reaction to potential or perceived danger. However, when the fear reaction develops into an irrational fear and impacts on a person's ability to function, it

develops into neuroses. Cognitive philosophies infer that the emotion or sensation of anxiety is evoked by the interpretation of events rather than a direct stimulus. Learned behaviour or conditioning is typically viewed as response-generated behavioural outcomes to anticipated stimuli that result in avoidant behaviour (Rachman, 2004).

This study explored the experiences of people who have attempted suicide and who required treatment and care from nurses within the generalist hospital setting. It explored the expectations of the professional leads within a healthcare service and identified the attitudes, behaviours and outcomes of the nurses who provide suicide aftercare and attempted to explain why these exist.

Researcher perspective

As a mental health nurse with many years' experience of working with people who are suicidal and with staff who provide care for people who are suicidal, I undertook a Masters qualification in Suicidology. People who know me are aware that I am comfortable talking with suicidal people and talking about suicide. Several years ago, a colleague of mine spoke to me following her experiences as a person admitted to a hospital following a suicide attempt. She acknowledges that she deliberately took an overdose of medication and subsequently was admitted to the Emergency Department (ED). Once her initial emergency medical issues were stabilised, she required further medical monitoring. She recalls that the handover from the ED nurse to the ward nurse was emotive in content, with her care transition and handover communication leaving her feeling rejected by the nurse and further questioning her self-worth. Paradoxically, the ward nurse

approached her with empathy and understanding and made herself available should she require time to talk. The differences in the approaches of these two nurses caused me to think about what determines a nurse's behaviour when providing care for people following a suicide attempt.

Significance of the study

The findings of this research provide significant information that has helped to develop a clearer understanding of the attitudes, behaviours and interactions of nurses as well as the needs of people who require suicide attempt aftercare. Moreover, it has provided information on the educational and support requirements of nurses when they are working with people who are receiving suicide aftercare. It is anticipated that the findings of this research will benefit nurses by providing them a clearer understanding of the knowledge, skills, attitudes and behaviours required when working with people who require suicide aftercare.

Aim of the study

The aim of the study was to explore the factors that influence the behaviours of nurses working in acute care settings and their skills and knowledge in relation to working with people following a suicide attempt.

Research questions

Four research questions underpinned the study:

1. Does anxiety explain the formation of attitudes and behaviours of nurses when providing suicide attempt aftercare?
2. What are the knowledge, skills and attitudes of nurses working in acute care settings when working with people following a suicide attempt and how are they explained?
3. What unit culture exists where people are treated following a suicide attempt?
4. Do nurses working in acute care settings have more negative attitudes towards people who present following suicide attempts on multiple occasions?

Objectives of the study

There were four objectives of the study:

1. Identify the elements of communication between nurses working in acute care settings and people who have attempted suicide.
2. Identify the nature of nursing activity which people who have attempted suicide receive from nurses working in acute care settings.
3. Identify the factors that influence the formation of attitudes of nurses working in acute care settings when people present following a suicide attempt.
4. Correlate the attitudes of nurses working in acute care settings to people who present on multiple occasions.

Declaration of Interest

The student researcher has a dual role within the organization where the research occurred, that of student researcher and that of Director of Nursing. This unequal relationship was made clear during information sessions with potential participants. It was essential that the potential participants voluntarily participated in the research without pressure or influence from the dual role. The Director of Nursing role has no professional or operational governance over the nurses within the wards where the research occurred.

The consumer participants were not advised of the student researcher's other role as Director of Nursing. It was thought that by making overt the dual role, the consumers might have experienced confusion as to the intent of the research. They only needed to know and identify the student researcher in that specific role.

Thesis format

This thesis is presented in seven chapters. Although each chapter has been written to be principally independent and complete, there are instances in the thesis where information is occasionally referenced to an earlier chapter to avoid redundancy. Table 1.2 specifies the format of the thesis.

Chapter One is the introductory chapter.

Chapter Two presents a narrative literature review where the literature is critiqued and summarized. This type of review that enables gaps in a body of knowledge to be identified. It reports on research related to the attitudes of

nurses, the delivery of suicide attempt aftercare and the experiences of people receiving suicide attempt aftercare.

Chapter Three elucidates the method and design of the study. It provides the context to the study setting and the participants . A multiple methods approach using quantitative surveys and qualitative methods including semi-structured interviews was used to explore nurses' attitudes and behaviours when they provide suicide aftercare from the perspectives of their Nurse Unit Managers, Clinical Nurse Educators and Directors of Nursing. Importantly, the experiences of people receiving suicide aftercare were also explored. The chapter also articulates the process for an Intervention Procedure, which was the process that was to be followed should suicide risk of a consumer be identified. Chapter Three also presents the ethical procedures for the study and well as data management and analysis.

Chapter Four presents the findings of the interviews and includes two manuscripts submitted to peer-reviewed journals for consideration for publication. There is also a discussion at the end of the papers.

Chapter Five presents the findings of the quantitative survey and includes two manuscripts, one in press and one submitted to a peer-reviewed journal for publication. There is a discussion at the end of each of the two papers.

Chapter Six provides a discussion using the Theory of Planned Behaviour as a theoretical underpinning, with the qualitative and quantitative components of the project examined in light of the extant literature and triangulated to provide avenues for discussion.

Chapter Seven concludes the thesis and postulates implications for practice, key recommendations and educational requirements required by nurses who provide suicide aftercare. It also offers suggestions for future research.

Summary of Chapter One

This chapter provides a summary of the thesis. It addresses the context and background to the topic of attempted suicide aftercare, including the author's personal experience and background information. It outlines the research questions and the aims and objectives of the study. It provides definitions of terms relevant to the study and finally outlines the structure of the thesis. Each of these components is important preparation prior to the review of literature in the next chapter.

Table 1.1: Summary of content of thesis 1

Chapter		Outline of Content
Chapter One	Introduction	Background Organisation of thesis
Chapter Two	Literature Review	Topics arising from literature
Chapter Three	Method and Design	Ethical aspects Broad research design – multiple methods Qualitative / semi-structured interviews / focus group Quantitative / survey tools
Chapter Four	Qualitative section	Two publications submitted
Chapter Five	Quantitative section	One publication in press One publication submitted
Chapter Six	Discussion	Discussion relating publications to theory of planned behaviour
Chapter Seven	Conclusion	Conclusion Implications for practice and education Recommendations for further research

Chapter Two: Literature Review

Introduction and search strategy

Suicide is currently one of the main public health concerns around the globe (WHO, 2014), and numerous factors leading to the increase in the prevalence of this issue require urgent action. Considering the vastness of this issue, nurses are well placed to assist people who are admitted to their care following a suicide attempt. Therefore, it is essential that they practise with the appropriate knowledge, skills and attitudes in order to care for this patient cohort. This chapter discusses the attitudes and behaviours of nurses in hospitals when providing aftercare services for patients following a suicide attempt. The four topics explored and critiqued arose from contexts revealed by the literature reviewed. The topics identified and discussed in this chapter are research into suicidology, help-seeking, interaction between nurses and consumers, and stigma.

The research literature was reviewed using a combination of methods because information about suicide is presented in the research literature, policies, grey literature and in social media reflecting lived experiences. The electronic databases PubMed, Australian Educational Index (AEI), PsycINFO, Professional Development Collection (EBSCO), and the Educational Resource Information Centre (ERIC) databases were searched using title and keyword searches, individually and in combination. Search terms included attempted suicide, attitudes to attempted suicide, health personnel attitudes, nurse attitudes to attempted suicide, general nurse attitudes to attempted suicide, suicidal patients,

and the impact of nurse attitudes and behaviour on suicidal patients. A total of 939 papers were initially identified, of which 25 met the inclusion criteria (see Figure 2.1). This chapter presents the analysis of data from existing literature, based on materials published in the last ten years, to ensure relevance and accuracy. The inclusion criteria permitted materials published in English within the last decade, therefore restricting the publication dates from 2007 to 2017, in order to avoid collecting outdated information, or literature that has been frequently discussed and cited. Equally, only research which dealt with suicide attempts was included for review. Therefore, research where deaths occurred as a result of suicide attempts was excluded from the review.

Relevant information was collected from various categories of publications including books and journal articles. Whilst academic databases are restricted to peer-reviewed articles, further searches by hand, otherwise referred to as manual (Elliot, 2007) or 'snowballing,' were conducted to identify further relevant publications that were not identified by searches of the computerized databases. Since health service policies and procedures specifically from the organization where this study was conducted do not exist for the delivery of suicide attempt aftercare, information could not be drawn from this source.

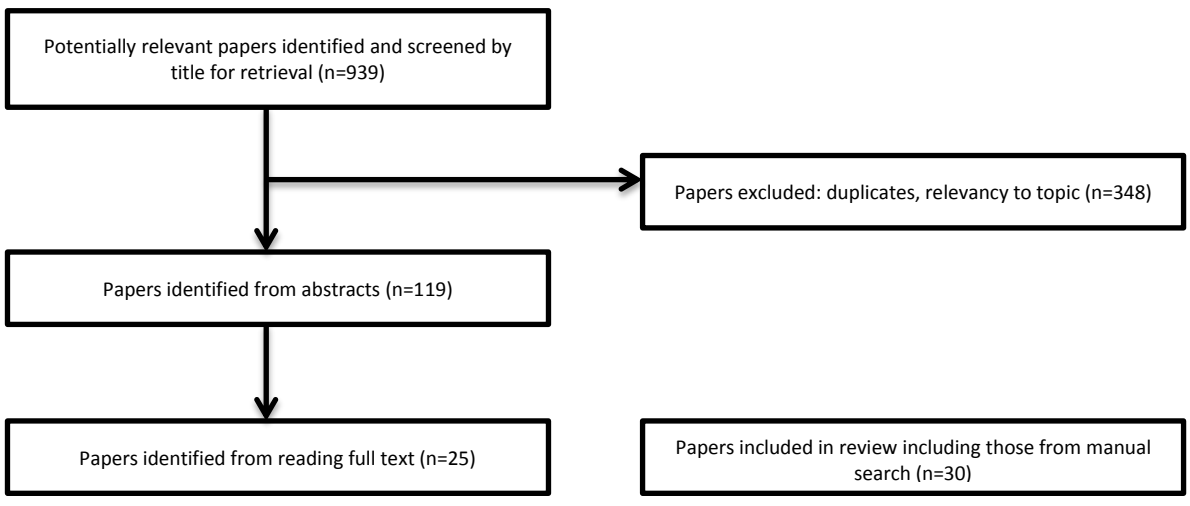

FIGURE 2.1: LITERATURE SELECTION FLOW CHART

Table 2.1: Peer reviewed articles

Reference	Aim	Participants	Method	Key findings
Mishara, B.L. & Weisstub, D.N. (2016) International Journal of Law and Psychiatry, 44, 54-74	To investigate globally, the various criminal codes regarding suicide	N/A	Review - 192 criminal codes were obtained from various countries and states	Suicide and attempted suicide is illegal according to 45 criminal codes. Penalties include imprisonment
van Landschoot, R., Portzky, G., & van Heeringen, K. (2017). International Journal of Environmental Research and Public Health, 14(3), 304-	To explore the effects of a suicide education poster on knowledge, self-confidence and attitudes of clinicians	1171 staff from 39 emergency and 38 psychiatric departments throughout Flanders	Multicentre cluster randomised controlled trial	Nil change in knowledge and self-confidence, however improvements in attitudes towards suicidal individuals
Vatne, M. & Nåden, D. (2014). Nursing Ethics, 21(2), 163-175	To explore patient experiences of being suicidal and interactions with healthcare clinicians	10 people: 4 women and 6 men aged 21-52 years	Qualitative interviews	Positive and negative aspects of openness and trust, receiving help and respect versus humiliation
van der Kluit, M.J. & Goossens, P.J.J. (2011). Issues in Mental Health Nursing. 32, 519-527.	To explain the factors underlying the attitudes of nurses in general health care toward the care of people with comorbid mental illness	N/A	Literature review	The exact relationship between knowledge, skills, education and attitudes remains unclear
Sun, F., Long, A., Huang, X. & Chiang, C. (2011). Journal of Clinical Nursing, 20; 837-846.	To investigate the outcomes on learning of a suicide education program	174 second-year nursing students in Taiwan	Questionnaire completed post suicide education program (n=95) and (n=79) who did not attend the session	Those students who attended the education program had more positive attitudes and knowledge than those who did not
Scocco, P., Toffol, E., Preti, A. & The SOPRoxi Project Team. (2016). Journal of Nervous and Mental Diseases. 204 (3), 194-202.	To test the effect of psychopathological distress of self-stigma in people who have attempted suicide	67 patients hospitalized after an attempted suicide	Interview and 2 questionnaires (90-item Symptom Checklist; Stigma of Suicide Attempt scale)	Previous suicide attempts lead to increased negative self-stigmatization and stigma
Saunders, K.E.A., Hawton, K., Fortune, S. & Farrell, S. (2012). Journal of Affective Disorders. 139, 205-216	To review staff attitudes towards people who engage in self-harm, and the impact of training on attitudes, knowledge and behaviour of staff.	N/A	Systematic review - 74 studies were included	People who self-harm are among the most negatively viewed patient cohorts. Mental health staff have more positive attitudes. In medical areas, doctors have more negative attitudes than

Reference	Aim	Participants	Method	Key findings
				nurses. Education impacts positively on attitude
Roush, J.F., Brown, S.L., Jahn, D.R., Mitchell, S.M., Taylor, N.J., Quinnett, P. & Ries, R. (2017). Crisis. Advance online publication.	To correlate relationships between fear of suicide-related outcomes and suicide risk assessment and management	Mental health professionals	Self-reported assessments	Comfort rather than fear was the greater predictor as to whether a clinician would undertake suicide risk assessment
Ouzouni, C. & Nakakis, K. (2013). Health Science Journal. 7 (1), 119-134	To explore the attitudes of nurses towards attempted suicide	Greek nurses working in medical, surgical, orthopaedic, emergency and ICU units across 4 hospitals	Survey using Attitudes Towards Attempted Suicide Questionnaire (ATAS-Q)	Overall the participants' responses indicated negative attitudes towards attempted suicide with mixed feelings when caring for these patients.
Norheim, A.B., Grimholt, T.K. & Ekeberg, Ø. (2013). BMC Psychiatry. 13(90).	To explore the attitudes towards suicide of mental health professionals comparing child and adolescent and adult outpatient clinics	229 professionals across 4 outpatient clinics in Oslo, Norway	Questionnaires using The Understanding of Suicidal Patient (USP) and Attitudes Towards Suicide (ATTS)	All participants indicated positive attitudes and that suicide is preventable
Horwitz, S.M, Heinberg, L. J., Storfer-Isser, A., Barnes, D. H., Smith, M., Kapur, R., Currier, G., Wilcox, H.C. & Wilkens, K. (2011). Pediatric Emergency Care, 27(7), 601-605.	To investigate a computerized program assists Residents skills in assessing and managing youth presentations	32 medical residents recruited from 1 medical centre in Cleveland, USA	Quasi-experimental post-test only design and self-rated pre-test knowledge of program content	Significantly higher post-test scores following completion of the computerized program
Kodaka, M., Poštuvan, V., Inagaki, M. & Yamada, M. (2010). International Journal of Social Psychiatry. 57(4), 338-361.	To assess attitudinal scales that measure attitudes toward suicide		Systematic review - 2,210 publications were scoped	3 scales were identified as meeting pre-defined criteria: Suicide Opinion Questionnaire (SOQ), Suicide Attitude Questionnaire (SUIATT) and Attitudes Toward Suicide (ATTS)
Jahn, D.R., Quinnett, P. & Ries, R. (2016). Professional Psychology: Research and Practice. 47(2), 130-138.	To examine relationships between suicide-focused training, professional experience, fear of suicide-related outcomes, comfort with	289 masters or doctoral level mental health practitioners	Online survey regarding training and experience working with suicidal individuals	Suicide focused education may reduce the negative association of fear and discomfort when working with suicidal individuals

Reference	Aim	Participants	Method	Key findings
	and skills in working with suicidal patients, and knowledge of suicide risk and protective factors.			
Hill, T, E. (2010). Philosophy, Ethics, and Humanities in Medicine. 5(11)	To explore moral judgement in healthcare		Literature review - 100 articles related to moral judgement in healthcare	Healthcare professional make moral judgements about their patients
Chan, S.W.C., Chien, W.T. & Tso, S. (2008). Journal of Clinical Nursing. 17, 2884-2894.	To evaluate outcomes of an education program on nurses' knowledge, attitude and competence on suicide prevention	2 general hospitals with 54 RNs from medical-surgical units	Focus groups	Participants reported increased levels of skills, confidence and attitudes when responding to suicidal individuals
Chan, S.W.C., Chien, W.T. & Tso, S. (2009). Hong Kong Medical Journal. 15(S6), S4-8.	To evaluate the effectiveness of a suicide prevention and management education program for nurses	2 general hospitals with 110 RNs from medical-surgical units randomly assigned to participate in the education program	Focus group interviews	Those who participated in the education program self-evaluated as having increased assessment skills and in caring for people who were suicidal
Bridge, J.A., Marcus, S.C. & Olfson, M. (2012). Journal of the American Academy of Child and Adolescent Psychiatry. 51(2), 213-222	To explore the follow up mental health care of young people following admission to ED after episodes of deliberate self-harm	3,241 ED treatment episodes by youth 10 to 19 years old for deliberate self-harm	Retrospective longitudinal cohort analysis	Many people do not receive ongoing mental health support following admission to ED and subsequent discharge to the community
Björkman, T., Angelman, T., & Jonsson, M. (2008). Scandinavian Journal of Caring Sciences, 22(2), 170–177.	The aim of the present study was to investigate attitudes towards mental illness and people with mental illness among nursing staff working in psychiatric or somatic care.	120 registered or assistant nurses	Interviews	Generalist nurses report a more negative attitude towards people with mental health issues than do mental health nurses
Berlim, M.T., Perizzolo, J., Lejderman, F., Fleck, M.P. & Joiner, T.E. (2007). Journal of Affective Disorders, 100(1-3),233-9	To evaluate a brief training program on suicide prevention for front-line general hospital personnel in terms of its impact	Forty non-clinical and 102 clinical staff employed in a university hospital in Brazil	Survey using Suicide Behavior Attitude Questionnaire [SBAQ] before the start and immediately after a 3-hour training on suicide prevention.	Attitudes and beliefs about suicide were improved post 3-hour training on suicide prevention

Reference	Aim	Participants	Method	Key findings
	on their attitudes and beliefs towards suicidality.			
Berglund, S., Aström, S., Lindgren, B-M. (2016). Issues in Mental Health Nursing, 37(10), 715-726.	To synthesize research on suicidal persons' experiences of the suicide process		A literature search and meta-synthesis of 15 articles	Hope is both an enabler and a barrier to attempted suicide
Pulido-Martos, M., Augusto-Landa, J.M., Lopez-Zafra, E. (2012). International Nursing Review, 59, 15-25	To review literature identifying stressors in nursing students		Systematic review of 23 articles	2 forms of stressors: academic and clinical
Bond, K.S., Jorm, A.F., Kitchener, B.A. & Reavley, N.J.	To evaluate effectiveness of Mental Health First Aid program	434 Nursing and Medical students in Australia	Pre-post survey after completion of face-to-face or online Mental Health First Aid program	Improved quality of first aid intentions, increased mental health literacy and decreased stigma

Table 2.2 Grey literature

Reference	Aim	Participants	Method	Results
Saigle, V.H. (2016). Suicide and Ethics: A review of practical issues that arise in clinical and research settings and their neglect in academia. (*Master's thesis*).	Exploration of ethical issues associated with suicide	98 articles	2 scoping studies: literature review of the ethical issues in suicide research and ethical dilemmas of health professionals when providing care for suicidal individuals	Ethical issues were deemed to arise because of a perceived sense of duty to prevent suicide.
Cutcliffe, J. R., & Stevenson, C. (2007). Care of The Suicidal Person. Edinburgh: Churchill Livingstone/Elsevier.	To investigate how psychiatric nurses provide care to suicidal individuals	Psychiatric nurses in the UK	Three year qualitative study	Provides clinical advice and guidance on how to undertake clinical practice with suicidal individuals

Table 2.3: Research-based, non-peer-reviewed grey literature

Reference	Summary
Mishara, B.L. (2007) Care of the Suicidal Person. Churchill Livingston, USA.	Foreword to the completed book based on a 3 year qualitative study undertaken in the UK of psychiatric nurses

World Health Organization (2014) Preventing suicide: a global imperative. Geneva.	This report builds on previous documents and offers a platform for two essential elements for future work: a guide for governments, policy-makers and relevant stakeholders based on current international knowledge of suicide and suicide attempt; and an actionable comprehensive multi-sectoral strategy for countries based on their current resources and contexts.
Senate Community Affairs Committee Secretariat. (2010). The Hidden Toll: Suicide in Australia. Canberra: Commonwealth of Australia.	This report provides outcomes on the form of recommendations arising from a Senate investigation into Australia's response to suicide.
De Leo, (2012). Suicide Research: Selected Findings	Foreword introducing the context to the bi-annual literature review conducted by the Australian Institute for Suicide Research and Prevention.
Centre for Research Excellence in Suicide Prevention, (2015). Care After A Suicide Attempt. Australia	A report prepared for the National Mental Health Commission based on research conducted via survey and qualitative interviews.
Kral, M.J., Morris, J. & White, J. (2017). Death Studies, 41(8), 469-471.	Editorial discussing the changing discourse of suicidology research from contemporary suicidology to critical suicidology.

Findings

Suicide is a major global health concern, not only due to its repercussions, but also due to its high prevalence. Worldwide, it is estimated that more than 800,000 people suicide yearly, resulting in an annual mortality rate of 11.5 deaths per 100,000 individuals (van LandSchoot, Portzky & van Heeringen, 2017). According to a report released in 2014 by the World Health Organization (WHO), the mortality rates resulting from suicide have been increasing at an alarming rate. The report also reveals that, on a global level, it is estimated that a person dies by suicide every 40 seconds (WHO, 2014). However, the report does not indicate specifics of age, gender, or race. Australia has a higher rate of suicide than other developed countries, such as the United Kingdom, Canada and the United States (WHO, 2017). According to the Causes of Death report released by the Australian Bureau of Statistics, the overall suicide rate in Australia in 2016 was 11.7 per 100,000 people (ABS, 2017). Whilst consideration of deaths by suicide is important and relevant, it is also necessary to measure the severity of the suicide phenomenon. Although in Australia suicide ranks 15th in leading causes of death (ABS, 2016), on a global perspective, suicide is ranked as the second highest cause of death among individuals from 12 to 29 years (WHO, 2014). Of note are the gender disparities in the suicide rate in Australia, with males suiciding at 17.8 deaths per 100,000 people and females at 5.8 deaths per 100,000 people (ABS, 2017). Whilst the number of deaths is alarming, so too is the estimation of 60,000 people attempting suicide in Australia each year, and although the death rates are higher in men, the majority of people who attempt suicide are women (Senate Community Affairs Committee Secretariat, 2010).

It is well recognized that there is significant under-reporting of the numbers of people who attempt suicide (Mishara & Weisstub, 2016; Senate Community Affairs Committee Secretariat, 2010; WHO, 2014). This may be attributed to a number of factors: individual recovery without healthcare intervention, determination of intent, issues of reporting, and stigma associated with suicide attempts (Senate Community Affairs Committee Secretariat, 2010). Stigma specifically is one factor that impacts on the formation of attitudes, and one that is displayed amongst nurses (Cutcliffe & Stevenson, 2007; Ouzouni & Nakakis, 2013).

Research into Suicidology

There has been an increasing number of peer-reviewed studies and publications in the suicidology literature (De Leo, 2012), with a shift away from contemporary suicidology to a focus on critical suicidology (Kral, Morris & White, 2017). Contemporary suicidology originated within the domains of psychology and psychiatry and focuses on suicide prevention, prediction, risk assessment, and treatment of various populations, and is primarily quantitative in nature (Kral, et al., 2017; Marsh, 2010). This traditional approach to suicide research, whilst providing for population-based interventions and generalizations, does not address the individual or first person contexts of suicide that are unique to critical suicidology (Kral, et al., 2017). Critical suicidology seeks to provide a voice to the experience of individuals and groups, with much of this research being qualitative in nature and seeking to revisit the perspective that suicide and attempted suicide is associated with mental health conditions (Kral et al, 2017). It is important to note the various groups who have

been identified as having increased risk of suicide within the Australian population: children and young people, the elderly, men, lesbian, gay, bisexual, transgender, and intersex (LGBTI), Indigenous Australians, people with mental illness, prisoners, culturally and linguistically diverse people and people in rural and regional communities (Senate Community Affairs Committee Secretariat, 2010). It is also to recognize that from a contemporary suicidology viewpoint, there are preventative activities that may be undertaken. However, these populations should also be explored from a critical suicidology perspective that would enable the integration of "context, culture, ethics, history, the political and the subjective" (Kral, et al., 2017, p.471) to provide a collective perspective.

Help-seeking

Individuals who experience major life challenges often engage with health care providers via self-presentations in the emergency department (Bridge, Marcus & Olfson, 2012; Horwitz, et al., 2011). Moreover, the emergency department is generally strategically located, to enhance the evaluation of the health condition of people, while also offering care for self-injuries (Bridge, et al., 2012). However, in a submission to the Parliamentary Inquiry on Suicide, the Salvation Army Australia observed that emergency departments are not often able to deliver the attention, support and care suicidal people require due to demands on resources and increasing acuity of other presentations (Senate Community Affairs Committee Secretariat, 2010). Recommendations from the Committee include suicide awareness and prevention training being made available to staff who provide clinical healthcare, are engaged in community service provision, or are providers of gatekeeper functions (Senate Community Affairs Committee

Secretariat, 2010). However, in the United States, the need for suicide-specific education has been refuted by professional bodies representing mental health organisations because they perceive that their staff are well versed and experienced in providing care for suicidal individuals (Jahn et al, 2016).

Interaction between Nurses and Patients

It is recognized that the interaction and communication between nurses and consumers who are suicidal are generally poor (Norheim, Grimholt & Ekeberg, 2013). A number of studies regarding the attitudes of clinicians to suicide attempts have largely shown that their attitudes are negative (Berlim, Perizzolo, Lejderman, Fleck, & Joiner, 2007; Saunders, Hawton, Fortune & Farrell, 2012; Sun et al, 2011). However, the majority of these studies were undertaken before 2005 and were therefore excluded from this literature review. A study conducted in Australia by the Centre of Research Excellence in Suicide Prevention (CRESP), reported that participants were more satisfied with the attitudes and knowledge of the staff who worked in medical departments within general hospitals than they were of mental health clinicians, crisis teams, suicide prevention teams and psychiatrists (CRESP, 2015).

Nurses tend to exhibit various behaviours that may negatively or positively impact upon patients (Norheim et al, 2013). It is, therefore, essential to ensure that interactions are fruitful, ultimately resulting in appropriate assessment and the implementation of effective care. Emotions that carry with them stress and burden, as experienced by nurses when caring for people following a suicide attempt because of the potentiality of future fatality, may influence attitudes and the ability to provide care (Norheim et al, 2013).

Some of the attitudes of healthcare professionals include irritation, anger, frustration and helplessness (Norheim et al, 2013; Ouzouni & Nakakis, 2013). Feelings of insecurity and anxiety are exhibited as avoidance of the patient, especially amongst those who previously encountered suicidal individuals (Jahn, Quinnett & Ries, 2016; Norheim et al, 2013). However, it has been suggested that the healthcare professionals who exhibit the most positive attitudes towards suicidal persons are psychiatric professionals, clinicians with post-graduate or specialist qualifications, and professionals with experience of providing suicide attempt aftercare (Norheim et al, 2013; Ouzouni & Nakakis, 2013).

The level of education also determines the knowledge that the nurse displays regarding risk factors for suicide attempts and the subsequent attitudes portrayed (Norheim et al, 2013; Ouzouni & Nakakis, 2013). However, since not all highly-educated clinicians have positive attitudes to people requiring suicide attempt aftercare, education is merely a contributing factor in the development of attitudes. It has been noted that although nurses are in unique positions to interpose when suicidal people are in their care, they have minimal education to support them in this role (Berlim et al, 2007). As a result, the educational preparation of undergraduate nurses must be considered, with universities and training organisations being obligated to provide education and support to future nurses. Numerous Australian studies have been undertaken regarding the educative preparation of undergraduate nurses and their ability to provide care for people with mental health issues (Happell, 2010). One study that reviewed the effectiveness of the Mental Health First Aid program on knowledge and attitudes found increased confidence of nursing students in providing assistance to people experiencing mental health concerns (Bond, Jorm, Kitchener & Reavley,

2015). These researchers concluded that such programs would benefit these students in their future careers (Bond, et al., 2015). It has been reported that education programs regarding suicide awareness, prevention and intervention have evidenced improvements in clinicians' attitudes to people requiring suicide attempt aftercare (Horwitz, et al., 2011; Ouzouni & Nakakis, 2013; van Landschoot, et al., 2017). It has been suggested that superficial or minimalistic care are not merely a reflection of poor attitudes, but are due to a genuine lack of knowledge and fear (Berlim, et al., 2007; Jahn, et al., 2016).

The attitude of nurses to suicidal people plays an important role in shaping their behaviour and the way they interact with consumers (Cutcliffe & Stevenson, 2007; Berlim, et al., 2007; Norheim, et al., 2013; van Landschoot, et al., 2017). It also plays a crucial role in determining whether the various risk mitigation measures implemented will be successful or prove futile (Norheim, et al., 2013; Sun, et al., 2011). With a positive attitude, supported by appropriate education, the behaviour of nurses can be shaped in a manner that allows them to identify and address the various risk factors that are presented by the suicidal person in the hospital setting (Berlim, et al., 2007; Sun, et al., 2011; van Landschoot, et al., 2017).

In most instances, only experienced mental health clinicians have the requisite capabilities, knowledge, and skills to undertake effective suicide risk assessment of consumers (Horwitz, et al., 2011). Therefore, the focus for health services should not only be increasing the skills and knowledge of clinicians, but also improving attitudes, behaviours, interactions and the resultant outcomes (Berlim, et al., 2007; Jahn, et al., 2016; Kodaka, Poštuvan, Inagaki & Yamada,

2010). In addition, the physical environment in medical/surgical wards, including the floor plan and design, creates challenges for nurses in providing suicide attempt aftercare (Chan, et al., 2008; 2009) as there are visibility limitations and equipment which is required to be present, but detract from risk mitigation strategies.

Characteristics specific to individuals also play a role in shaping the attitudes, behaviours and interactions of nurses when providing suicide attempt aftercare. Such characteristics include age, gender and religion (Cutcliffe & Stevenson, 2007; Norheim, et al., 2013; Ouzouni & Nakakis, 2013). Some reports indicate a relationship between the age of the nurse and attitudes, with older nurses tending to hold a positive attitude to suicide attempts (Sun, et al., 2011; van der Kluit & Goossens, 2011). One systematic review revealed that it is not the gender of nurses, but the gender of the consumers, that has a weak impact on the attitudes and responses of nurses (Saunders, et al., 2012). Although no specific illness or condition can be solely attributed to suicide, mental health is believed to be the leading contributor of suicidal thoughts or attempts (WHO, 2014). Mental illnesses may include depression, schizophrenia and bipolar disorder. Male nurses tend to have a negative attitude to consumers experiencing mental illnesses, contrasting with the perception that female nurses are considered to be more caring of consumers exhibiting behaviours and symptoms that reflect risk of suicide (Björkman, Angelman & Jonsson, 2008). However, other reports identify contradictory correlations, where females tend to discriminate against consumers with comorbid mental illnesses, whereas this is not evident in their male colleagues (Björkman, et al., 2008). Nurses with strong religious beliefs or

affiliations tend to have a better and more positive relationship with consumers experiencing comorbid mental illnesses, in comparison to nurses with less robust religious views (Cutcliffe & Stevenson, 2007). Suggestions abound that there are attitudinal differences amongst clinicians depending on the consumer age group, with those who provide care for younger consumers exposed to greater degrees of care burden (Norheim, et al., 2013).

Stigma

Consumers relate negative care experiences, such as humiliation, non–empathetic care, compromised autonomy, unavailable care staff, poor communication and avoidance (Berglund, Aström, Lindgren, 2016; Norheim, et al., 2013). Other perspectives proffered represent how positive nurse attitudes make for meaningful interactions by offering hope and dignity, are supportive and safe and enable personal resilience (Berglund, et al., 2016). One of the main factors that increases the risk of suicide is stigma, both internal and external (Scocco, Toffol, Preti, & The SOPRoxi Project Team, 2016). Internal stigma limits the ways in which people access health care and engage with healthcare providers, exhibits as superficial interactions during hospitalization, and is enhanced further if a person has previously engaged in suicidal behaviour (Scocco, et al., 2016). Common amongst people who attempt suicide, discrimination resulting from stigma and largely compounded by feelings of shame, tends to override a persons' coping mechanisms, increasing their risk of suicide (Scocco, et al., 2016).

Nurses' experience is also a major factor in the formation of attitudes to suicide attempts. It has been suggested that nurses with extensive clinical backgrounds

are more likely to provide the care required for consumers' suicide attempt aftercare than their less experienced colleagues (Berlim, et al., 2007). However, clinical experience may also be biased by personal exposure to suicidal behaviour in their home life, with fear and anxiety contributing to avoidance of consumers in the workplace (van der Kluit & Goossens, 2011). In most instances, less experienced nurses tend to be unaware of the impact their attitude and subsequent actions have on suicide prevention activities (Cutcliffe & Stevenson, 2007; Mishara, 2007). However, a study conducted in Taiwan found that levels of experience did not contribute to variances in attitude (Sun, et al., 2011). The authors of this study suggest that rather than wait for nurses to garner experience, the provision of a suicide education program would be beneficial (Sun, et al., 2011). This was countered by another study that indicated years of experience did not correlate with the amount of suicide-specific education and subsequent feelings of fear associated with providing suicide attempt aftercare (Jahn, et al., 2016).

The perception of resources, including that of workload, also influences the attitudes and behaviours of nurses (Horwitz, et al., 2011). One such barrier to staff accessing suicide prevention and awareness education is the time required to participate which detracts from clinical work (Horwitz, et al., 2011; Jahn, et al., 2016). Workload is also viewed as a way in which nurses emotionally distance and protect themselves from the role through the adoption of task-based duties (van der Kluit & Goossens, 2011). This emotional distancing permits them to focus on duties and chores rather than the delivery of care and any resultant emotions (Hill, 2010), but also further separates the nurse from the consumer and their ability to provide suicide attempt aftercare (Vatne & Nåden, 2014).

Roush, et al. (2017) use the term "fear of suicide-related outcomes" to describe the anxiety experienced by health professionals when providing suicide attempt aftercare. They rationalize that fear associated with potential consumer death is a natural reaction, given the deleterious consequences of suicidal behaviour (Jahn, et al., 2016; Roush, et al., 2017). Poor decision-making and practice have been attributed to fear and anxiety experienced by health workers, subsequently leading to the inability to provide care as required, or to "reinforce suffering and reduce hope for a better life" (Vatne & Nåden, 2014, p173). However, this fear and anxiety may also contribute to positive actions enabling interventions (Vatne & Nåden, 2014). One systematic review identified that nursing students experience two sources of stress, academic and clinical, which include the fear of unknown situations (Pulido-Martos, Augusto-Landa & Lopez-Zafra, 2012), supporting the notion that nursing is inherently anxiety-provoking. The anxiety experienced by both mental health specialists and non-mental health professionals when working with people post-suicide attempt has been reported to be similar (Jahn, et al., 2016). Jahn, et al. (2016) suggests that it is imperative that the fear experienced by clinicians when caring for people post-suicide attempt and the impact of this emotion upon consumer engagement are explored.

In the literature, when providing suicide attempt aftercare, nurses' behaviours are described, explored and categorized. However, none of the research literature examined in this study provided a model that attempted to explain the behaviours of nurses when providing suicide attempt aftercare. This led to the

decision to adopt the Theory of Planned Behaviour (Ajzen, 1985) as a theoretical model.

Chapter Summary

This chapter commenced with a narrative and context of the global burden of suicide. This was followed by an exploration of the research literature pertaining to research into suicidology, exploring the traditional perspectives of contemporary suicidology and introducing the modern views of critical suicidology. Barriers and enablers of help-seeking were discussed. The expressions of attitudes and subsequent factors influencing the development of these were highlighted in an exploration of the interactions between nurses and consumers. Stigma was examined from both the personal experiences of stigma, but also factors that influenced nurses' expressions of stigma, including their years of experience, perception of available resources and anxiety.

There are number of contributing factors that when combined inform attitudes to suicide attempts. Many of the emotions highlighted by nurses who provide suicide attempt aftercare are the result of anxiety. The gap in the knowledge identified from this literature review is how anxiety and suicide attempt aftercare are inter-related. Hence, further research is recommended to explore the anxiety of nurses and their provision of suicide attempt aftercare.
Whilst this chapter has focused on what has come before in the context of the research literature, the next chapter establishes the direction and framework of the research for this thesis.

Chapter Three: Design and Methods

This chapter provides a description of the broad research design for the project as a whole: an exploratory descriptive study utilising multiple methods presented as a series of interrelated components. Data were collected simultaneously, and when this occurs, neither qualitative nor quantitative data are privileged (Cresswell, 2011).

Exploratory descriptive designs allow for a variety of perspectives to be explored in relation to the attitudes and behaviours of general nurses when providing suicide attempt aftercare. As the term suggests, exploratory research allows for the exploration of a research topic, without the expectation that it is conclusive in its findings. Descriptive research examines the characteristics of a single sample population; in this study the focus is the attitudes and behaviours of medical/surgical nurses when providing suicide attempt aftercare.

Multiple methods research is pragmatic in nature, in that the research undertaken may be viewed as discrete cluster studies that could be considered to be complete inquiries in their own right (Morse, 2003). These series of separate studies can then be triangulated to form the essential elements of the broader matter under investigation (Morse, 2003). The utilisation of a combination of data collection and analysis methods contributes to a deeper understanding of the attitudes, behaviours and interactions of nurses working in acute care settings when providing aftercare for people following a suicide attempt.

Paradigm

Paradigms are the assumptions that underpin beliefs and practices and influence researchers regarding the selection of subject matter and how that subject matter will be examined (Morgan, 2007). Plowright (2011) refutes the need to have a precise philosophical stance prior to commencing any research. Instead, he reports that an integrated methodology allows the researcher to have a less restricted slant and one that is aimed at answering the research question or solving a problem (Plowright, 2011).

The research paradigm used in this study is that of pragmatism. It was selected because the fundamental underpinnings of pragmatism capture the essence of human experience in any undertaking by considering their own reality and influence (Johnson & Onwuegbuzie, 2004; Nowell, 2015), and by focusing on the personal experience of individuals (Cornish & Gillespie, 2009; Nowell, 2015). Importantly, pragmatists question whether the research they conduct and the results influence the individual either negatively or positively (Cornish & Gillespie, 2009). When conducting research, it is important to consider the approach or approaches that best suit the research questions to be addressed. Pragmatism allows for this to occur, by permitting a combination of methodologies in order for researchers to best address their enquiries (Johnson & Onwuegbuzie, 2004; Kettles, Creswell & Zhang, 2011). Table 3.1, based on a table in Creswell & Plano-Clarke (2011), represents the general characteristics of pragmatism when viewed with the paradigm features of ontology, epistemology, axiology, methodology and rhetoric relevant to this study. Nowell (2015) considers it essential that pragmatists consider personal ideals and principles,

concepts, deeds and interfaces prior to seeking explanations or outcomes when planning research. In clinical healthcare environments, practice locations and within nursing, knowledge attainment is dependent upon multiple and varied perspectives, that often diverge and may even be conflictual (Nowell, 2015). By recognizing these varied perspectives, often captured through a number of approaches, comprehensive understandings of the world being explored may be enhanced (Nowell, 2015).

Paradigm feature	Pragmatism
Ontology	Hypotheses are tested as the research question has primary significance
Epistemology	The researcher is practical in approach and has the autonomy to be eclectic in choosing techniques in order to collect information
Axiology	Values are provided as a multiple stance in that both objective and subjective perspectives and biases are included
Methodology	The process of research is viewed as a number of distinct cluster studies, forming into multi-method research; both quantitative and qualitative methods are used to answer the research question following a process of triangulation
Rhetoric	The language used may be formal or informal

Theoretical and conceptual framework

Research on suicide is typically undertaken using a positivist approach with quantitative studies to measure and explain current understandings within this domain (Kral, Links & Bergmans, 2012). Few suicidology studies utilize pure qualitative designs or mixed method research (De Leo, 2002; Lakeman &

Fitzgerald, 2008), indicating that they are typically quantitative (Kral et al, 2012). Kral et al (2012) clarify that whilst there is a dearth of research on the personal experiences of the suicidal person, it is vital to ensure contemporary knowledge and subsequent help that may be provided. This is of particular interest from a nursing perspective, given the importance of the patient's own experiences and how these experiences influence and inform practice, education and research (Beck, 1994).

Koshy, Koshy and Waterman (2011) assert that when selecting a method, there are two important factors to consider: first, that the method suits the research objectives or questions, and second, ensuring the quality of the data to be collected. Selecting a method is vital to a researcher since, as Al-Hamdan and Anthony (2010, p52) state, "we might answer the questions but not understand the answers".

In a discussion of how quantitative and qualitative studies can work collaboratively, Lester (2002) explains that the ongoing debate over methodology preference or value in suicide research is meaningless; the selection of a method should depend on how each method can augment the style of the alternative method. This is supported by Goldney (2002), who asserts that both quantitative and qualitative methods are required in suicide research, as alone, they are unable to adequately explain some phenomena. By utilising both quantitative and qualitative methods as discussed by Lester (2002) and Goldney (2002), without integration of research results, the researcher may risk ascribing results to only the distinctive and separate components of each method (O'Cathain, Murphy & Nicholl, 2008). Separately, quantitative and qualitative

methods focus on singular aspects of study: the broad universal perspective and the narrow individual perspectives (Kral et al, 2012). Multi-method research or methodological pluralism is used when different research methods are needed to examine one area within one context using different questions and approaches (Morse, 1999). When triangulated, the results deliver diverse perspectives on the question being investigated (Morse, 1999). Although researchers typically have a preference for the research methodology they select to conduct their studies, there are inherent limitations in both qualitative and quantitative styles (Lamont & Swidler, 2014). When considering a research strategy, it is important to consider the various elements of the research methods utilised and their relationships to one another. Triangulation draws from a broad base of information obtained from a number of sources, including theories, investigators, data, methodologies and analysis, which are combined so that the interpretation of these sources leads to the research findings (Azulai & Rankin, 2012; Farmer, Robinson, Elliott & Eyles, 2006).

Methodological triangulation occurs when research outcomes are substantiated using a combination of research methods (Azulai & Rankin, 2012). More explicitly, methodological triangulation is classified into within-method triangulation and between method-triangulation (Azulai & Rankin, 2012). Within-method triangulation occurs when researchers utilise two or more data collection techniques within the same methodology, qualitative or quantitative (Azulai & Rankin, 2012). Between-method triangulation is a term used to describe "the combination of methodologies in the study of the same phenomenon" (Denzin, 1978, 291 in Jick, 1979, p.108). In the present study, methodological triangulation was achieved using the typology of between-

method triangulation (Figure 3.1). This occurred through the utilisation of quantitative techniques to collect survey data, as well as the qualitative procedures of individual interviews and focus groups.

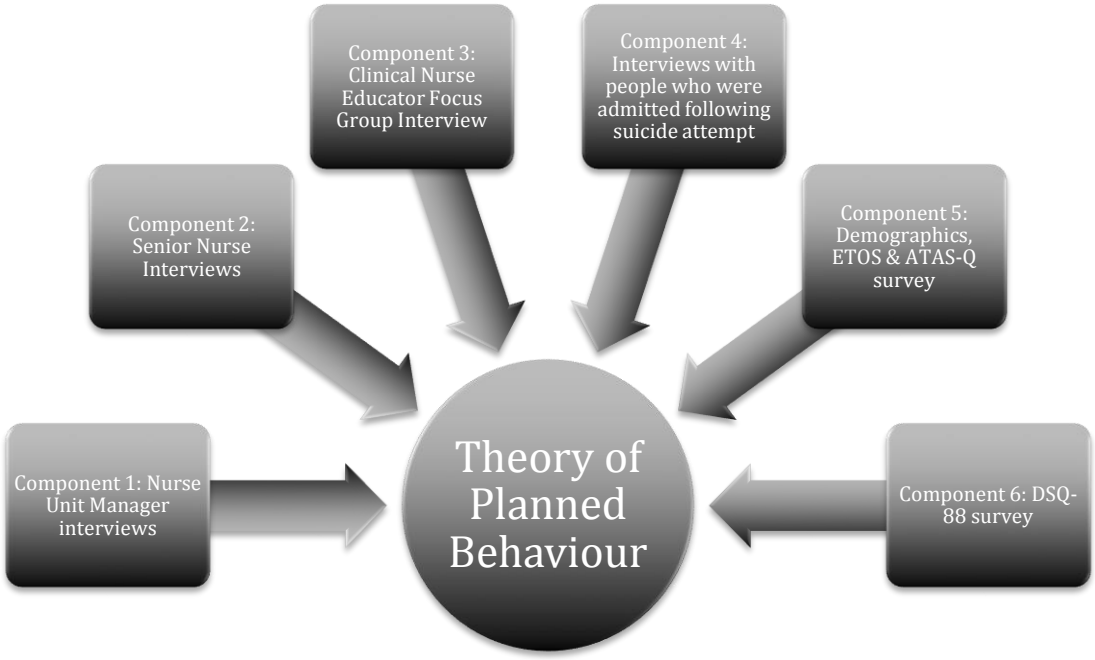

Figure 3.1: Between-method triangulation using theory of planned behaviour as conceptual underpinning.

Within the domain of multi-methods, the use of a combination of approaches allows for the information being collected to be cross-validated in order to provide greater depth to what is being studied (Jick, 1979). Triangulation may be viewed as an end point to multi-method research, as its purpose is that of substantiation and completeness; it provides a more robust outcome than could be ascribed to one methodology alone (Al-Hamdan & Anthony, 2010; Fenech Adami & Kiger, 2005; Azulai & Rankin, 2012).

Based on these assumptions, triangulating a combination of data collection methods from a range of different participant perspectives and analysis methods

contributes to a deeper understanding of the knowledge, skills and attitudes required by nurses working in acute care settings when providing aftercare for people following a suicide attempt.

Theory of Planned Behaviour

The theoretical framework adopted as a basis for the conceptual underpinnings of this study was the Theory of Planned Behaviour (Ajzen, 1985). This theorywas preceded by the theory of reasoned action (Fishbein & Ajzen, 1975). Both of these theories are based on the assumption that behaviours are an outcome of intent, which is in turn derived from norms or beliefs (Ajzen, 2005). Therefore, the behaviour that is enacted is inherently consistent with the beliefs held, irrespective of whether these beliefs have been formed based on informed or irrational constructs (Ajzen, 2011). Figure 3.2 is a pictorial representation of the theory of planned behaviour.

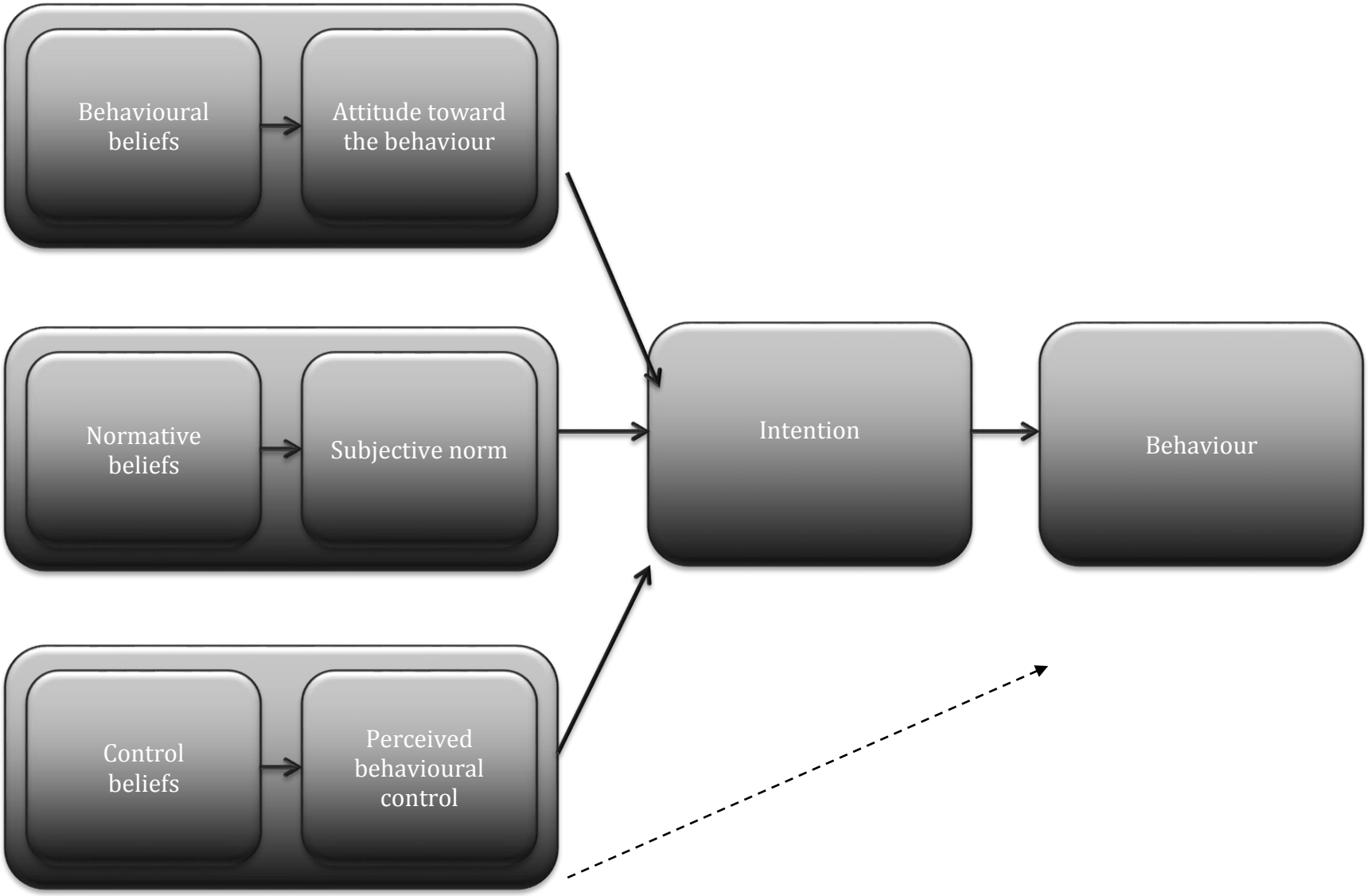

Figure 3.2: Pictorial representation of Theory of Planned Behaviour (Ajzen, 1985)

Beliefs are formed when certain attributes are associated with an object or thing and are viewed either positively or negatively. People subsequently respond to that object based on their premise (Ajzen, 1993; 2005). Favourable attitudes are then acquired towards objects that are considered to have positive characteristics, and negatively to the inverse (Ajzen, 2005). The strength of one's beliefs depends on the subjective value placed on the attributes.

As depicted above, the theory of planned behaviour presumes three concepts that are considered to be separate determining factors of intent: attitude toward the behaviour, subjective norm and perceived behavioural control (Ajzen, 1989). Attitude toward the behaviour is linked with behavioural beliefs and directly correlated with the positive or negative connotations of the consequences of behaviour (Ajzen, 1989; 2005). Subjective norms relate to an individual's perception that society expects them to behave in a given way. Perceived behavioural control denotes the perception one has of the ease or difficulty of enacting behaviour and is influenced by past experience and observations of others (Ajzen, 1989; 2005). Neither attitude toward the behaviour nor subjective norms have direct influences on behaviour, but rather moderate intent (Steinmetz, Davidov & Schmidt, 2016). A central tenet is the notion that intention must exist and is an antecedent of that which is behaviour (Ajzen, 1989; 2006). Actual behavioural control refers to the tangible skills and resources of individuals to actually perform behaviour. When a person does not have the requisite degree of actual behavioural control, perceived behavioural control is used as a substitution. Consequently, the behaviour evidenced is reflective of previous experiences (Ajzen, 2005).

Table 3.2 provides information on the procedures adopted in the various components of this study and provides detail as to how the study was undertaken.

Ethics Approval

Ethics approval was sought and obtained from the health service human research ethics committee (HREC-B). The health service and university have a reciprocal agreement regarding ethics approval and ethics approval was therefore granted by the university (Appendix 1).

Ethical considerations

Caring for people who are or have been suicidal and admitted to hospital for treatment presents a set of dilemmas for healthcare organizations, clinicians, families and patients themselves. Whilst there is an imperative to protect the privacy of the suicidal patient, the health and wellbeing of the individual is paramount. Nurses working with this vulnerable group must be cognizant of the ethical principles and potential dilemmas for nurses and researchers.

Ethical principles to be considered in this study included those of paternalism, autonomy, non-maleficence, beneficence, justice and fidelity. There are a variety of possible ethical responses by nurses to situations in which patients who have attempted suicide are considered to be incapable of making decisions that are in the best interest of life-preserving efforts. One such justification is paternalism, which is based on the notion that a person must be incapable of having rational thoughts or is mentally unwell to want to die and subsequently their capacity for making decisions is therefore impaired (Clarke, 1999). Hence,

Table 3.2: Flowchart of research procedures

Flowchart of procedures used in this multi-method study	
Step 1	**Design and implement the quantitative strand:** • Design quantitative research questions and determine the quantitative approach • Obtain permissions (ethics approval from HREC-B) • Identify the quantitative sample (RNs and ENs who work within the 6 medical and surgical units identified as providing suicide aftercare in a major metropolitan health service.) • Collect closed-ended data with instruments (demographic data collection, ETOS, ATAS-Q, DSQ-88) • Analyse the quantitative data using descriptive & inferential statistics
Step 2	**Design and implement the qualitative strand:** • Design qualitative research questions • Purposefully select a qualitative sample (patients receiving suicide attempt aftercare, Directors of Nursing, Senior Nurses, Nurse Educators.) • Collect open-ended data; semi-structured interviews and focus group interview • Analyse the qualitative data using van Manen's (2016) phenomenological procedure for thematic analysis
Step 3	**Use strategies to follow from the quantitative results:** • Determine which results will be explained • Prepare papers for publication
Step 4	**Use strategies to follow from the qualitative results:** • Determine which results will be explained • Prepare papers for publication
Step 5	**Interpret the connected results:** • Summarize and interpret the qualitative results • Summarize and interpret the quantitative results • Utilise the process of triangulation to discuss to what extent and in what ways the qualitative results help to explain the quantitative results and vice versa

nurses who hold these beliefs may adopt a paternalistic manner. In this case, nurses rationalize and adopt an approach of proxy decision-making because they consider that consumers *'don't know better and it is for their own good'* because of perceived impaired capacity (Fry & Johnstone, 2008). In over-riding a person's

decisions and choices, paternalism rejects the autonomy of the individual. Autonomy is the recognition of an individual's self-determination. However, extending autonomy, without limits, to people who have made a suicide attempt may infer permissiveness and subsequently lead to further attempts or death (Cutcliffe & Stevenson, 2007). Paternalism is based on the principles of non-maleficence and beneficence. Non-maleficence refers to the provision of nursing care in a way that ensures people are safe from harm. This permits nurses who provide care to people following suicide attempts to employ risk-mitigation and harm-reduction strategies. Beneficence means that nurses provide care not just treatment, and may act in conflict with consumers' wishes, particularly those of a suicidal person, as beneficence also requires the nurse to do good for the patient. Intervention when a person is suicidal may conflict with what the patient believes is good for them, which in turn is paternalistic. Justice ensures that all people, irrespective of societal position, political beliefs or financial status, receive equal access to nursing care, and that treatment is fair. It is a requirement that nurses consider and treat everyone the same way with respect and dignity. Fidelity requires nurses to ensure that their clinical skills and knowledge are current, evidence-informed and underpinned by a theoretical philosophy. Nurses who do not maintain their currency of practice and knowledge risk espousing outdated perspectives, and deficits in knowledge and skills may place a suicidal person at greater risk.

Consent and capacity

Obtaining informed consent is an important procedure undertaken in any research study, with participants being provided with adequate information

regarding the research in order for them to determine whether they agree or decline to participate (Polit & Beck, 2017). Consent from the nurses for the cross-sectional survey questionnaire was implied by the completion and return of the survey. Informed consent was obtained from the NUMs, Senior Nurses and CNEs following dissemination of information regarding the research.

As consumer participants were people who have made suicide attempts, they form a vulnerable group. However, this vulnerable population should not be excluded from participating in research because non-involvement perpetuates significant barriers to progressing knowledge in this area (Lakeman & FitzGerald, 2009). When c consumers consented to participate their capacity to consent was assessed. The Evaluation to Sign Consent (ESC) form was completed after the provision of information outlining the study purpose, identifying potential risks, and informing them of the research processes prior to the research participation consent process being undertaken. Participants were provided an opportunity to ask questions. The ESC is a five- item tool that assesses the comprehension of information (DeRenzo, et al., 1998). The five items are that the potential participant

1. Is alert and able to communicate with the researcher
2. Can list any risk from study participation
3. Can identify what is required as part of study participation
4. Can explain the process for consent withdrawal
5. Can identify procedures to follow should distress or discomfort occur as a result of the study.

Successful completion of the ESC form requires potential participants to respond accurately to the above items and if they can, they are deemed to have the capacity to participate. If any item is answered incorrectly, the researcher

may prompt by repeating the information once, and then repeat the question a second time. If the question is answered incorrectly again, informed consent is delayed for 24 hours. If at the second attempt an item is answered incorrectly, informed consent is not obtained from that consumer.

The Mental Health Act of Victoria, implemented in 2014, refers to Capacity under Section 68 (p.69) and outlines that a person has capacity to provide informed consent if He or She:

- *Understand*s the information provided
- Is able to *remember* the information
- Is able to *use or weigh* the information
- Is able to *communicate* the decision he or she makes.

The notion of presumption of capacity is important in this study because prior to the new Act (2014), the historical context of capacity often excluded people acting with self-determination if they were receiving treatment under the previous Mental Health Act of Victoria (1986).

Privacy

One important aspect that is essential when conducting research that involves people, recognizing that it intrudes upon their lives, is that they are afforded and assured privacy when participating (Polit & Beck, 2017). All interview and focus group participants were allocated a pseudonym for anonymity purposes.

Data storage

Assuring individual privacy extends to the collection and maintaining of data (Polit & Beck, 2017). All data obtained through this study have been stored and

maintained in a locked cabinet accessible only by the student researcher for a period of seven years, whereupon it will be destroyed in accordance with University guidelines.

Study setting

The study was undertaken in Victoria's largest public health service in south-east metropolitan Melbourne, Australia. It provides healthcare to over 1.2 million people, offering services across the entire life span, from pre-birth to the elderly, as well as numerous clinical specialties. It employs over 17,000 staff across 40 different care locations, including hospitals and community settings. Service provision includes but is not limited to emergency services, acute health, maternity, rehabilitation, paediatrics, palliative care, surgery, aged care, mental health and general medicine. Each year more than 3.6 million episodes of care are provided, with more than 260,000 people admitted to the hospitals. The local population is a diverse, multicultural community that is growing by more than 450 new residents moving into the catchment area each week. The local communities who access this health service are born in more than 180 different countries, and speak 100 different languages. Assistance was requested from the Directors of Nursing of three of the hospitals in order to identify potential wards where this study could be conducted. Consumers who have attempted suicide are generally admitted to one of these wards from one of the multiple Emergency Departments to an appropriate clinical specialty in order to deliver the treatment and care required. Therefore, the units identified as the receiving medical and surgical wards for people following a suicide attempt were selected.

Components 1, 2, 3 & 4: Qualitative Method

Since the qualitative method has its foundation in the human experience, the data collected are typically subjective and narrative in nature (Polit & Beck, 2017). In the present research, the method of data collection undertaken was interviews and a focus group discussion. Interviews were conducted in order to ascertain a 'snapshot' of consumer care experiences and to garner perspectives of senior nurses. Semi-structured interviews were selected as the mode by which the consumer, Nurse Unit Manager and Senior Nurse interviews were conducted. All interviews proceeded with four standard indicative interview questions (Table 3.3, 3.4 and 3.5). The responses to these questions then informed the ongoing questions.

Recruitment

The Nurse Unit Managers were contacted by the student researcher via email to invite them to a meeting to discuss the research that would be occurring in their wards. These NUMs were recognized for their leadership roles within wards and were selected by their respective Directors of Nursing because they admitted consumers subsequent to a suicide attempt. The student researcher contacted via email the Directors of Nursing of each hospital and their Chief Nursing and Midwifery Officer to invite them to participate in interviews. Consumers were recruited via the unit champion who was the Nurse Unit Manager, Clinical Nurse Educator or Consultation Liaison (CL) Nurse. CL nurses are made aware of every patient who is admitted to acute care following a suicide attempt and were therefore well placed to assist with consumer recruitment. Information about the

project was provided to consumers, and if they were interested in participating they confirmed this with the unit champion who contacted the researcher in order for the interview to be conducted. The Clinical Nurse Educators allocated to each of the wards included in the study were invited by email to participate in a focus group. Endorsement of the study by the Directors of Nursing and Chief Nursing and Midwifery Officer may have influenced the recruitment of participants, such as the NUMs and CNEs (Polit & Beck, 2017). In addition, the decision to participate may have been influenced by participants considering the research to be relevant to their experiences (Polit & Beck, 2017).

Interviews

Interview methods utilised by researchers inherently rely upon the trust and rapport established with participants to aid in rich data collection (Boswell & Cannon, 2007). Interview techniques typically address items which cannot be included in closed-ended surveys, as the free structure of the interview process and subsequent fullness of the responses require comprehensive documentation and transcription of audio (Boswell & Cannon, 2007). Interviews not only capture the verbal communication, but also allow the researcher to investigate further non-verbal cues and their related meaning within the interview (Boswell & Cannon, 2007). Beyond the traditional approach to interviewing, which seeks answers to questions, interviews also enable the collection of data "about representations, classification systems, boundary work, identity, imagined realities and cultural ideals, as well as emotional states" (Lamont & Swidler, 2014, p157). This is because the interviewer can delve into participant responses

through conversational interactions (Lamont & Swidler, 2014).

The interviews were held at a day and time scheduled between the interviewer and participant and conducted in private office spaces. Participation in interviews and focus groups was voluntary.

Table 3.3 Indicative interview question (Nurse Unit Managers)

Indicative interview questions (Nurse Unit Managers)
Describe the atmosphere of the unit when it is known that the ward will receive a patient who has made a suicide attempt. *Is it different to when other patients are admitted? Is the atmosphere different for the duration of the admission?*
When you have a patient who has been admitted following a suicide attempt, what is your biggest concern?
As a Nurse Unit Manager, do you think that nurses on your unit are adept at providing care to people following a suicide attempt? *Expand*
Do you think the perception of nursing care provided by nurses differs from that experienced by patients who are receiving care following a suicide attempt? *How?*

Table 3.4 Indicative interview question (Senior Nurses)

Indicative interview questions (Senior Nurses)
What are your expectations of the nurses and the care that they provide to those people?
Do you think the nurses themselves have an understanding of what is considered to be safe, or safety, when looking after this cohort of patients?
What is your biggest concern when you have nurses put in situations in which they might not feel confident or capable of looking after someone?
Where do you think the professional responsibility lies?

Table 3.5 Indicative interview question (Nurse Unit Managers)

Indicative Interview questions (Consumers receiving suicide attempt aftercare)
How would you describe the experience of being cared for by nurses? Has there been a care moment that sticks in your mind?
Would you feel comfortable discussing your suicide attempt with the nurses caring for you?
Can you discuss what the nurses do for you?
Do the nurses discuss how you are feeling? And your suicide attempt with you?
Do you think the nurses treat you any differently to anyone else? What do you base this on?

Focus Group

A focus group was conducted with Clinical Nurse Educators who work with nurses who provide treatment and suicide attempt aftercare. A focus group was selected as the most appropriate approach to capture the knowledge and skills of the Clinical Nurse Educator group. They are employed by the health service and work with nurses who provide suicide attempt aftercare, and have all worked in the clinical setting as nurses. Focus groups are often used when there are a group of participants who have a particular skillset or knowledge base in the area in which the research is occurring (Richardson-Tench, Taylor, Kermode & Roberts, 2011). Essential elements of focus groups are the interactions that occur amongst the participants as they convey their thoughts, perspectives and opinions (Richardson-Tench, et al., 2011; Jayasekara, 2012). A key consideration when establishing a focus group is ensuring that every voice is heard; this means that it is vital that the researcher has group facilitation skills (Richardson-Tench, et al., 2011). The focus group was held at a date and time suitable for the researcher and Nurse Educators and conducted in a large private meeting room at one of the hospitals.

Intervention Procedure

An intervention procedure was adopted to ensure that all consumer participants had access to mental health support during the research. Mishara and Weisstub (2005) consider it essential that when involving people who may be suicidal in research about suicide, researchers employ an intervention procedure in case of identified risk, mental distress or suicidal ideation/plan. The term Intervention Procedure is used to replace the term Rescue Procedure (Mishara & Weisstub,

2005) because rescue implies a sense of hopelessness and non-self-determination. The student researcher is a skilled and competent mental health nurse, with good assessment skills and ability to conduct these assessments 'in action'; that is, the context and content of verbal and nonverbal communication can be interpreted contemporaneously to assess for critical risk factors associated with risk of suicide.

If these risk factors were identified as being present, acute and immediate, the student researcher undertook a suicide intervention utilizing the Applied Suicide Intervention Skills Training (ASIST) model (https://www.livingworks.net). One of the steps in this model is to notify others, and in this case, the person would be referred back to mental health Consultation Liaison for follow-up.

Levels of distress process

In any instances where a level of distress was detected in consumers, the process of notifying the Consultation Liaison team occurred as per the Intervention Procedure. Following all interviews and focus group the nurses were encouraged to contact the Employee Assistance Program utilized by their employer should they experience distress.

Qualitative Data Analysis

The interviews and focus group were conducted using a digital audio recorder enabling verbatim transcription of the voice recordings. Each transcript was allocated a code which indicated the participant's area of work and/or hospital setting. The consumer interview transcripts were allocated a code indicating that they were a consumer, a pseudonym and the hospital setting. The transcripts

were analysed using van Manen's phenomenological procedure for thematic analysis (van Manen, 2016). van Manen believes that lived experience interviews can be readily captured and understood when they are viewed in their entirety and then subsequently treated to a process of deconstruction (van Manen, 2016). This is a three-stage approach, comprising the wholistic [sic] approach, the selective approach and the detailed approach (van Manen, 2016).

After the reading of the transcript in its entirety, the first stage considers the primary significance of the text (van Manen, 2016). After reading selected passages more than once, the second stage requires that text considered to be of value to the experience is highlighted (van Manen, 2016). Finally, the third stage requires the researcher to examine in detail each sentence as a standalone in order to ascertain what it may reveal about the experience (van Manen, 2016). The themes that arise from this process may then be interpreted and composed into notes and given meaning (van Manen, 2016). Once the interviews were transcribed, the transcripts were read for initial identification of themes. Following this step, repeated commentary or clarification was highlighted, as it was deemed to offer valuable subjective experiences. The final stage required the reviewing of each sentence independently of others. This enabled the qualification of theming and provided context to the stories and experiences of the participants. Confounding the interpretation of qualitative information, narrative data as described by Plowright (2011) are subject to the interpretation of the researcher as the data may be ambiguous and have meanings within the layers of communication.

Research Rigour

In order for multiple methods to attract the same degree of recognition as qualitative and quantitative research, researchers must ascribe the same levels of evidence, indicating that results are authentic and sound (Richardson-Tench, et al., 2011). However, although accomplishing research rigour in multiple methods research is difficult as it is not yet clearly defined (Halcomb & Hickman, 2015), there is an expectation that the criteria for rigour of both quantitative and qualitative methods are met (Cresswell & Plano Clark, 2011). Quantitative research design is couched in schemas that assure reliability and validity (Richardson-Tench, et al., 2011). All quantitative data were collected using instruments that have been validated.

To attain the qualitative notion of trustworthiness, which is a term used to ensure that findings are accurate and truthful, four criteria must be established: credibility, dependability, confirmability and transferability (Polit & Beck, 2006).

The concept of prolonged engagement led to the establishment of credibility. Whilst qualitative interviews need not be lengthy, the depth and familiarity between researcher and participant is valued (Lincoln & Guba, 1985). This is of particular importance when participants are provided the time and space to articulate their responses from their own perspective. By having key prompting questions, the researcher was afforded the flexibility to explore themes that arose in each discrete interview. The lived experience of participants was treasured.

In order to affirm dependability, external panelists were sought to review the

research plans and data collection methods and provide feedback in order to ascertain a measure of independent consultation. Throughout the data analysis, the researcher's supervisors undertook independent analysis of the transcripts. Participants were also offered the opportunity to review the transcripts of their interviews**.** However, no participants elected to review them.

The qualitative components were reported upon utilising the consolidated criteria for reporting qualitative research (COREQ) checklist, as its purpose is to ensure completeness, transparency, credibility of data, rigour and inclusivity (Tong, et al., 2007). During the process of participant recruitment, the student researcher clearly identified that she held a dual role within the organization. This was in order for participants to appreciate the researcher's background and knowledge and potential bias (Malterud, 2001).

Whilst this study was conducted within one health service in Victoria, Australia, the qualitative findings can be transferred broadly, as the themes that arose addressed similar content and results as other studies. Data saturation was met as the interviews did not reveal new data.

Components 5 & 6 : Quantitative Survey

This component utilized a cross-sectional survey approach to gather data on demographics, defence mechanisms, therapeutic optimism and attitudes to attempted suicide by nurses working in generalist hospital environments (Richardson-Tench, et al., 2011).

Cross-sectional surveys are commonly used in research because not only do they provide a snapshot of a single point in time in participants' experiences, but also

because they are relatively quick, easy and cost-effective to administer (Jolley, 2004; Richardson-Tench, et al., 2011; Sedgwick, 2014;). Pools of participants can be derived based on various characteristics and variables and are therefore suitable for approximating the prevalence of a disease or behaviour within a population (Jolley, 2004; Sedgwick, 2014). However, because of the once-only approach, cross-sectional surveys cannot be used for making inferences of cause and effect (Jolley, 2004; Sedgwick, 2014).

Instruments

Three instruments informed the cross-sectional survey, and additional demographic data were collected to assist with identification of the specific individualities of the participants in order to extrapolate information based on these characteristics. Due to the strong psychometric properties of the instruments, it was deemed not necessary to conduct a pilot study with this population. The instruments were delivered either via SurveyMonkey (SurveyMonkey, 2014) or in hard copy as a single pack. The combination approach to the distribution of the surveys meant that the total number assumptions cannot be inferred. Assumptions may only be drawn from anticipated staffing numbers, which were 270.

Elsom Therapeutic Optimism Scale (ETOS)

The Elsom Therapeutic Optimism Scale (ETOS) is typically used in mental health settings to measure the level of optimism experienced by clinicians, relative to the effect of their interactions with consumers (Happell et al, 2012). Whilst

typically used in mental health settings, the ETOS has also been used with midwives (Lau et al, 2015). It is a 10 item, 7-point Likert-type format, anchored by *strongly disagree* and *strongly agree*. Positive optimism correlates to higher scores (the highest possible score is 70). The ETOS is reported to have adequate internal consistency and reliability, with Cronbach's alpha ranging from 0.81-0.89 (Elsom & McCauley-Elsom, 2008; Happell et al, 2012).

Attitudes to Attempted Suicide-Questionnaire (ATAS-Q)

The Attitudes to Attempted Suicide-Questionnaire (ATAS-Q) (Ouzouni & Nakakis, 2009) is used to measure attitudes towards attempted suicide. The ATAS-Q has 80 items that assess 8 factors: *positiveness*, *acceptability*, *religiosity*, *professional role and care*, *manipulation*, *personality traits*, *mental illness* and *discrimination*. The questionnaire is a 5-point Likert-type format, anchored by *strongly disagree* and *strongly agree*. Negative attitudes correlate to low score ratings (the lowest score is 80), whilst more positive attitudes correlate to high score ratings (the highest score possible is 400). The ATAS-Q is reported to have high construct and face validity (Ouzouni & Nakakis, 2009; Ouzouni & Nakakis, 2012; Ouzouni & Nakakis, 2013). Two independent researchers have determined that the ATAS-Q Cronbach's alpha (0.97) reflects high internal consistency (Ouzouni & Nakakis, 2012; Ouzouni & Nakakis, 2013).

Defense Style Questionnaire (DSQ-88)

The Defense Style Questionnaire (DSQ-88) (Bond & Wesley, 1996) measures 20 defences and four defence styles (Cramer, 2006). The DSQ-88 assesses four

defence styles: *maladaptive action, self-sacrificing, image-distortion and adaptive* (Ramkissoon, 2014). The questionnaire uses a 9-point Likert scale to reflect the degree to which the participant agrees or disagrees with a statement. The DSQ-88 is reported to have adequate test-retest reliability (Ramkissoon, 2014; Perry & Cooper, 1986)

Participants and sampling method

The participants in this study were Registered and Enrolled nurses who worked in the six specified medical and surgical units at three hospital campuses of the health service identified above. Information was provided to potential nursing participants verbally during a local in-service (accessing the handover period) of each respective unit. The researcher conducted these sessions. Information sheets were also distributed at this point, and flyers were placed in staff areas. Frequent reminders were sent via email to each Nurse Unit Manager in order to increase participation rates. In addition, the ward Consultation Liaison Nurses or Nurse Educators promoted the study during their attendances on the ward. Participants were aged over 18 and were capable of providing informed consent. Nurses who were not present during the data collection period (for example, on maternity leave, annual leave, and long service leave or long-term sick leave) were not included in this study.

Quantitative Data Analysis

Responses to the cross-sectional survey were entered into SPSS - Version 25 (IBM, 2017) and both descriptive and inferential statistics were applied including correlations (Pearson product-moment correlation and Spearman

rank-order correlation), t-tests and analysis of variance (ANOVA). Correlations are conducted to examine affiliations between the characteristics of individuals within a group (Richardson-Tench, et al., 2011). Independent samples t-tests are conducted to determine whether there are statistical differences in mean scores for two discrete groups on the same variable (Richardson-Tench, et al., 2011). ANOVAs are conducted in order to determine whether disparities exist in mean scores for more than two discrete groups (Richardson-Tench, et al., 2011)

Conclusion

This chapter has presented the research design and methodology, the theoretical and conceptual framework, the theory of planned behaviour, intervention procedure, data collection and analysis methods.

The next chapter presents the findings of the qualitative research, presented as papers submitted to peer-reviewed journals.

Chapter Four: Qualitative findings

Chapter four presents the results of the four qualitative components of the research, with papers submitted for publication forming the base to which the discussion is centred. Table 4.1 provides a summary of the qualitative papers presented within this chapter. A discussion follows the presentation of the two papers.

Table 4.1: Summary of qualitative papers

Research Process Components	Qualitative Approach Component One	Qualitative Approach Component Two
Design	Descriptive, exploratory	Descriptive, exploratory
Participants	Purposive sample of 5 Nurse Unit Managers, 7 Clinical Nurse Educators, 4 Senior Nurses	Purposive sample of 9 Consumers
Data Collection	Semi-structured interviews	Semi-structured interviews
Analysis	Thematic analysis	Thematic analysis
Findings	Suicide anxiety is made up of sub themes: not being person centred, risks & communication.	Two main themes comprising four aspects. The themes are: needing to protect and facing blame. Aspects are: for nurses, for themselves, internal and external.

Paper One:

Clinical governance for people following a suicide attempt: Senior Nurses expectations and perceptions.

Submitted to Nursing & Health Sciences

Abstract

Little is known about the perceptions and governance of Senior Nurses regarding their nursing staff behaviours and attitudes when providing care to people following a suicide attempt. It has long been recognised that nurses report providing suicide attempt aftercare is difficult and can be tremendously frustrating. This study was conducted using a qualitative exploratory approach across three metropolitan hospitals in Victoria, Australia. Data were collected between July 2015 and September 2016. Semi structured interviews (n=16) were conducted with senior nurses (non-mental health). The interviews were recorded, transcribed and subjected to van Manen's thematic analysis. There were major themes of not being person centred, risks and communication evident. The behaviour exhibited by nurses is driven by what we have construed as *suicide anxiety*. This is demonstrated through the emotional, social and behavioural distancing of the nurse delivering care and subsequently providing only the necessary tasks and functions of the nursing role. Suicide anxiety is a confounding factor for nurses. Suicide anxiety is provoked by the nurse's recognition of another person's potential death attributed to his or her own hand.

Key words: suicide anxiety, communication, nursing care, suicide attempt

Background

Suicide is multidimensional (Talseth & Gilje, 2011) and noted to be characterised by an intricate interplay of biopsychosocial, environmental and cultural facets (0'Connor, 2011). Early proponents of suicide research have explained that the suicide attempt may be viewed as a desire to end pain (Osborne, 1989), including that of "psychache" (Schneidman, 1995, p51). Pain encompasses more than physical and includes spiritual, emotional, psychological and social discomfort. The wish to die is also inherent in the experience of demoralization, the core of which is hopelessness (Clarke & Kissane, 2002). It is estimated that the number of people who attempt suicide is 23 times the number who die by suicide (De Leo, Cerin, Spathonis & Burgis, 2005). The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (2016) identifies four precursors as risk factors for suicide: drug and alcohol misuse, economic adversity, isolation and previous attempts of self-harm. People who experience these four precursors are those who receive care from nurses (Lakeman, 2010). Notably, suicide attempt aftercare is provided in the aftermath of a situational or personal crisis (Lakeman, 2010) when people are often at their most vulnerable. It is also important to note that although one in five people may experience a mental illness in their lifetime (Australian Bureau of Statistics, 2007), not all people who experience mental health issues attempt suicide.

It is recognized that nurses are required to care for people who are or have been suicidal, irrespective of their clinical specialty (McAllister et al, 2002; Lakeman, 2010) and that nurses in medical and surgical services may care for people who have attempted suicide or have suicidal thoughts and are admitted to their wards for aftercare (Lakeman, 2010). It is therefore essential that nurses have the requisite knowledge, skills and attitude to deliver this care. While nurses may not understand the reasons for attempting suicide, they should be able to respond with carefully chosen words thoughtfully and sensitively (Santa Mina et al, 2009). Shea (2002) recognizes that attitudes towards suicidal persons exist, but considers that individual awareness of one's own attitudes towards suicide allows for nurses to be both psychologically and emotionally accessible and to provide the level of care required. Anxiety is a constraint that inhibits nurses from being accessible due to an internal personal reaction to real or potential incidents that cause "uncertainty, unknowing and insecurity" (Brady, 2015, p33). These nurses must receive appropriate support and governance. This paper explores the voice of senior nurses, who develop governance strategies to provide their essential perspectives in an attempt to understand the experiences of nurses they lead when providing suicide attempt aftercare.

Worldwide, nursing is considered to be one of the most trusted professions, recognized for ethics and honesty (Roy Morgan, 2016; Girvin et al., 2016). This professional capital, arising from the way in which the public view nurses as a collective is embodied by nurses redressing social justice issues in order to ensure that people receive the best possible nursing care (Lasiter et al., 2015). Nurse Unit Managers (NUMs), Clinical Nurse Educators (CNEs), Directors of Nursing (DONs) and Chief Nursing Officers (CNO) form part of the nursing hierarchy regarding the professional and clinical governance of health services. Professional governance, as described by the UC Davis Medical Center is a formal construct by which direct care nurses actively participate in decision-making

activities that contribute to the delivery of nursing care. Clinical governance refers to "the system by which the governing body, managers, clinicians and staff share responsibility and accountability for the quality of care, continuously improving, minimising risks and fostering an environment of excellence in care for consumers/ patients/ residents" (Australian Council on Healthcare Standards, 2004, p4). Personal governance is the moral compass that directs the way in which an individual chooses to live their life. It is based on individuals' values, professional goals and self-imposed expectations (Hausammann, 2016). Bennett et al (2012), endorse the mandate that quality care can only be provided where there is diligent governance. As part of the standards for practice of the Registered Nurse or the Enrolled Nurse, the Nursing and Midwifery Board of Australia (NMBA) has determined that each nurse is responsible for their own actions (NMBA, 2016a, 2016b). The NMBA also requires that nurses maintain their currency and scope of practice in the area or specialty to which they work. The Australian Council on Healthcare Standards (ACHS) stipulates that in order to deliver high quality and safe care, organisations must provide risk management resources and systems (Australian Council on Healthcare Standards, 2013).

Methods

The Consolidated criteria for Reporting Qualitative studies (COREQ) checklist was utilised in the design and execution of our study (Tong et al., 2007). The COREQ checklist was designed specifically for appraisal of qualitative research with the intention ultimately increasing the credibility of this method of research (Tong et al., 2007). The 32-item checklist is structured to report across three domains of research team and reflexivity, study design and analysis and findings (Tong et al., 2007).

Design

This was an exploratory qualitative study using a single semi-structured interview with senior nurses to ascertain their expectations and experiences of medical/surgical nurses who provide care to people following a suicide attempt, which was part of a larger multi-component study.

Setting and organisational structure

The study was conducted in one large metropolitan health service in south eastern Melbourne, Australia that has three hospitals where medical and surgical nursing care is provided. Each NUM and CNE reports to a Director of Nursing who subsequently reports to the Chief Nursing Officer for professional matters and to a General Manager for operational matters.

Participants

A purposive convenience sample of senior nurses comprising of seven CNEs, three DONs and one CNO (n=11) and the Nurse Unit Manager sample comprising five NUMs (n=5), was undertaken for the semi-structured interviews. Thus (n=16) semi-structured interviews were conducted.

Data collection

Semi structured interviews were conducted by XX between July 2015 and September 2016. There were four standard prompting questions that were asked of all participants.

These were developed from the literature and from clinical experience of all the researchers (XX, YY and ZZ). The indicative questions are identified in tables 1 and 2. The prompting questions for the NUMs was different from the other senior nurses, as they have nurses who provide direct clinical care reporting to them. They are also accountable for localised resource allocation, contrary to the others.

Table 1 Prompting interview questions (Nurse Unit Managers)

Describe the atmosphere of the unit when it is known that the ward will receive a patient who has made a suicide attempt. *Is it different to when other patients are admitted? Is the atmosphere different for the duration of the admission?*
When you have a patient who has been admitted following a suicide attempt, what is your biggest concern?
As a Nurse Unit Manager, do you think that nurses on your unit are adept at providing care to people following a suicide attempt? *Expand*
Do you think the perception of nursing care provided by nurses differs from nurses to that experienced by patients who are receiving care following a suicide attempt? *How?*

Table 1 Prompting interview questions (CNEs, DONs & CNO)

What are your expectations of the nurses and the care that they provide to those people?
Do you think the nurses themselves have an understanding of what is considered to be safe, or safety, when looking after this cohort of patients?
What is your biggest concern when you have nurses put in situations in which they might not feel confident or capable of looking after someone?
Where do you think the professional responsibility lies?

Interviews

The interviews were conducted at a time and place of convenience to the participants and they were interviewed once only. The interviews ranged from 12 minutes to 43 minutes and were digitally audio-recorded enabling verbatim transcription. Each transcript was allocated a unique code.

Role of the researchers

The researcher involved in interviews was a Director of Nursing at the health service during the time of the study, and affiliated and undertaking her PhD with Monash University. She has longstanding experience as a mental health nurse, with postgraduate qualifications in suicidology. Her operational role had no professional governance over the participants. The other researchers hold professorial roles within the university sector. They both confirmed data analysis and have extensive experience in qualitative research.

Data analysis

All interviews were transcribed verbatim. This transcription was then subject to van Manen's three procedures of analysis by which thematic statements are isolated (van Manen, 2016). First, wholistic reading, which entailed reading and re-reading of the transcripts in order to identify key words and phrases. Second, the selective approach

where sentences and phrases were highlighted as identifiable themes. Finally, detailed reading to explore beyond each sentence or phrase to determine what each reveals about the construct under investigation (van Manen, 2016).

Ethical consideration

Ethics approval was obtained from both health service and university, human research and ethics committees. All participants received written information about the study and provided written consent for their participation and verbal consent for the audio recording of the interview. They were all allocated pseudonyms to protect their identity. Due to the sensitive nature of the topic, participants were provided with the opportunity to debrief following the interview and reminded that the health service counselling service was available to support them. The interviewer (XX) could seek debriefing from the other researchers (YY & ZZ), though that was not required.

Rigor

Transcript data were analysed by one researcher (XX) and verified independently by the other researchers (YY & ZZ). Participants were also invited to review the transcript for completeness and clarity and each was also asked to provide feedback regarding the preliminary findings. These activities were conducted in compliance with the COREQ checklist and as much as is possible within qualitative research, the researchers bracket their pre-conceived notions (Firmin & Injeti, 2013). It is difficult to assume that the participants interviewed represent the truth and experiences of all senior nurses were they to be interviewed, however the notion of generalisations has been discussed within limitations of the study. The authors aimed to present the results so that the findings are an accurate representation of the phenomena they are intended to present (Anderson, 2010). Selected quotes that are poignant or most representative of the research findings were used, and are indicative of the theme. In this way, the quote is not the only quote related to a theme, rather, it is the most representative of all quotes related to the theme. Where it is written 'One participant', this should not be interpreted as meaning only one participant said this. Rather, one quote is provided.

Findings

All participants were women, aged between 35 and 58. They had been in senior nursing roles for between two and twenty-five years. Although each participant had unique experiences and opinions, there were a number of commonalities that they shared. Three themes arose from the data: not being person centred, risk and communication, which are further defined as: emotions, failure to care, environment, resources, capability, avoidance, macabre interest and stigma. The participants acknowledged that their professional expectations of nurses providing suicide attempt aftercare were not always met in clinical practice. They recognized the complexities of providing care for this cohort of patients, simultaneously expecting that both the physical and emotional needs of patients are met. The emotional context experienced by nurses was highlighted as a hurdle in providing non-judgmental nursing care. Misunderstanding and inability to recognise the associated risks concerned the participants who believed that they contributed to inadequate comprehensive nursing care. The lack of confluence between professional governance demands and delivery of clinical care is evidenced throughout the themes.

Not being person centred

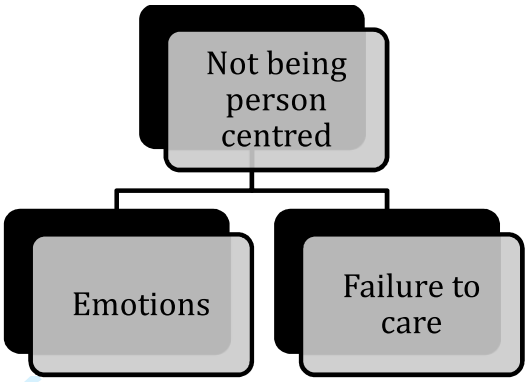

Figure 1: Major theme and sub themes of not being person centred

Participants recognised that their expectations were not matched by the delivery of care provided by nurses, with the acknowledgement that nursing care should be provided holistically, inclusive of emotional and mental health needs. One participant reported that as well as attending to physical health needs, nurses should also be available to provide emotional support and empathy. However, she also recognized that this does not occur consistently, adding that beyond the handover process further discussions are frequently held between nurses in places such as the tearoom or the corridor. Another participant reported that nurses care for the condition, not necessarily the person. She credited this to contemporary healthcare environments that require nurses to deliver practical skills in highly technological and hectic situations.

> *"…if we are to be truly providing holistic care and involving the consumer, then we can't pretend that there is no mental health component to this patient, and just deal with the physical." Sandra*

Nevertheless, meeting the mental health care needs of this patient group demands skills in therapeutic communication. Sandra also believed that there were differences in nursing care provided to patients who had attempted suicide compared to other patients who may for example, have cancer. She attributed this to the nurse's attitude, and that sometimes only physical care is provided;

> *"I don't know that we talk to them, really provide that nurturing that we maybe give to someone else." Sandra*

There was the acknowledgement by Jane that every patient requires individualised care, which is attributable to his/her unique personal experiences (see Figure 1). In her opinion, nurses need to modify their care to meet individualised experiences;

> "*It's about person centredness because you'll not get two patients who require that [sic] same needs who's attempted suicide. So whatever the nurses would be able to do to support that person is all about individualized person centredness." Jane*

The inability to combine the requisite knowledge and skills in order to deliver appropriate care, results in care that is not person centred. The participants indicated

that they expected nurses to deliver holistic care, and all that that entails and executed without judgement.

Belinda stated:

> *"I would expect their care to be as equally high standard and as equally responsible and responsive as anyone else…and that those patients would feel that they were not being in any way judged or compromised."*

However, this statement is balanced by responses when participants were asked about feelings that are evoked when caring for suicidal and people who self-harm. These were expressed as antipathy, frustration and anxiety (See figure 1). One participant reported that providing suicide attempt aftercare impacts on nurses because of a perception that the attempt is behaviour-driven in order to attract attention.

> *"…feel sorry for the person because they've tried numerous times. Also then almost …anger's the wrong word, but a resentment…it's that attention seeking behaviour. I think that people perceive [this] is what these people are doing in some cases" - Laura*

Risk

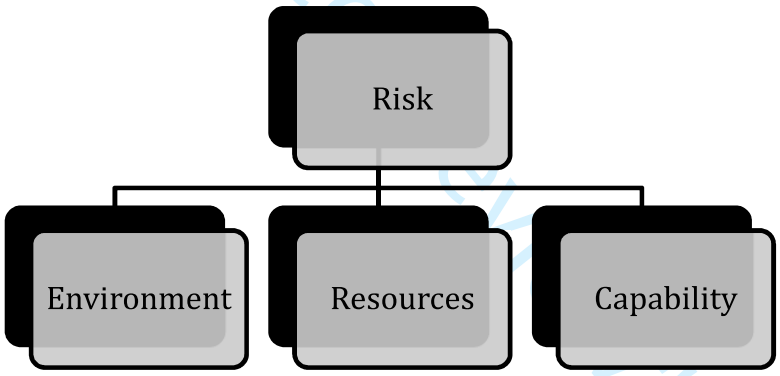

Figure 2: Major themes and sub themes of risk

Risks are managed everyday by nurses and strategies are implemented to mitigate risk, particularly when looking after a person who has been assessed as being at risk. One participant acknowledged that nurses receive patients who have attempted suicide and who remain actively suicidal, but risk mitigation strategies are not implemented. Another participant stated that although nurses care for people admitted to their ward following a suicide attempt, these nurses did not have a clear understanding of the associated risks (figure 2). Acute medical and surgical wards are filled with a plethora of equipment required to assist, monitor and treat the physically compromised person. These environments could be considered to pose significant risks and provide opportunities to people who may seek opportunities for harm. Participants stated that the setting is not conducive to providing a safe environment and cited examples of telephone cords and suction tubing being used in further suicide attempts on their

wards (figure 2). It was suggested that nurses' fears escalate because they do not have risk reduction strategies in place and the knowledge and critical thinking they employ in other areas of their work is deficient when they care for a person post suicide attempt (figure 2).

Whilst senior nurses are responsible for setting the standards related to clinical governance in their organization, they acknowledge that each nurse is responsible for their own scope of practice, including assessment and management of risk (figure 2). Cathy explained; *"Ultimately the nurse is responsible for that patient's safety and wellbeing once they've been admitted into our service."*

It appeared that some senior nurses had little understanding regarding the changeable nature of an individual's suicide risk level. They were able to acknowledge external risk factors, but did not comprehend internal risk factors such as perceived hopelessness, social isolation, lack of connectedness and despair. This is concerning when organizations rely on these leaders to assess and mitigate risks. According to one participant;

> *"If somebody just sits in here and they don't do anything, they don't say anything, and hopefully they're not silently contemplating, we're not as worried" Lisa*

This statement infers that nurses only become alerted when someone is actively suicidal, but are relieved when people appear to be passive indicating that they do not recognize internal risk factors (figure 2). It also implies that the nurses do not offer the opportunity to the person to express their feelings and thoughts (figure 1).

Resentment, frustration, anger and anxiety were described as the emotions experienced by the nurses caring for this patient cohort. Anxiety was attributed to fear of the patient attempting suicide in a general ward and particularly during their shift. Additionally, the emotional energy required to provide care and support detracts from both the time and the resources available to other patients, who are often perceived as more deserving. Cathy reported that some of the frustration stems from the differential value that is placed on the person because of their presentation and probably relates to not being person-centred (figure 1);

> "*…why didn't you do it right the first time, or why are you taking up a bed that we need for a very sick patient?" Cathy*

> *"…can't they see that we're pretty busy here and there's [sic] very sick patients trying to get into these beds?" Cathy*

Others stated (figure 2):

> *"I think that there's a sense of fear and anxiety. I sense that there is a tendency to want to just get the patients out, or to just special them" Sandra*

> *"I guess from a staff's point of view, someone comes in with anything like that, where they can't deal with, then they want one-on-one specials…that's not always necessarily needed but that is the anxiety of the staff on the ward" Laura*

Communication

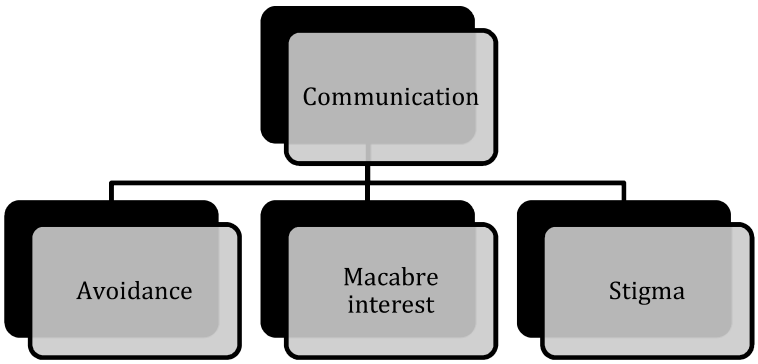

Figure 3: Major themes and sub themes of communication

Participants reported that nurses often engaged in a range of technical tasks instead of engaging with the person. Exploring the notion of busy work or purposeless activity, participants stated that nurses may spend more time around the suicidal patient, which they attributed to the nurse being accountable for that patient (figure 3). Others attributed the increased busy work and technical activity as a legitimate way that nurses can show their concern rather than spending time in therapeutic engagement with the patient.

> *I think that's the excuse, they don't know how to talk to patients." Sandra (figure 1 & 2)*

All participants conceded that there are knowledge and skills gaps associated with providing nursing care beyond the usual physical (figure 2). They attributed this knowledge gap to lack of education and training in suicide prevention and care, causing nurses to be unable to provide the psychological care needed. This has implications for their education requirements and the focus of care delivery. People, irrespective of their presenting complaint should receive care that is based on evidence and performed by skilled, educated nurses (figure 2).

Counselling was viewed as an adjunctive process, and not one the generalist nurse could or should provide. It was discussed that even if nurses were prepared to talk to the patient, they would be fearful about asking the right questions and struggle to respond if the person acknowledged that they remained suicidal (figure 1, 2, 3). Laura reflected on the tension experienced by nurses as to whether they explore a person's level of suicidal intent:

> *"I still think there is an underlying anxiety when people don't know how people are going to respond" Laura*

Participants believed that nurses avoided discussions with a person about their thoughts because they are anxious about the potential of increasing further thoughts of suicide or distress was a greater risk (figure 1, 2, 3). Avoiding engagement in meaningful conversation alleviated the anxiety (figure 3). Moreover, they considered that the environment was not conducive due to a lack of privacy (figure 2). When asked to what degree the conversation is held between nurse and patient, one NUM reported that it:

> *"Depends on how engaged the patient is, I think. As to how receptive they are…To engage more in that, they sometimes can escalate, so I think people tend to choose to withdraw a bit more" Brooke (figure 1, 3)*

Communication between staff was another area participants identified as problematic, particularly during the handover between shifts. The NUMs identified that when transferring information about the suicidal person, the handover frequently contained extraneous information that may not be relevant for the person's ongoing care (figure 3). They alluded to this additional information as appearing more important to nurses than actual clinical information to such an extent that handover can border on social and clinical voyeurism.

> *"It's definitely handed over in kind of hushed tones…and people are constantly discussing how much that person has taken or what they've taken. It's definitely a bigger source of discussion than if someone was admitted with just pneumonia" Stacey (figure 3)*

Discussion

This study aimed to ascertain expectations of the senior nurses governing medical and surgical nurses who provide care in the aftermath of a suicide attempt. Three major themes emerged: *not being person centred, risk* and *communication* emerged.

Suicide attempt aftercare involves a complex interplay of nursing strategies that ultimately reside in the act of being person centred. The basis for being person centred is the philosophical underpinning regarding viewing people as individuals (McCormack et al, 2010). Person centred care extends on this, with nurses recognising and providing for the individual needs of patients in a truly respectful manner (McCormack et al, 2010). Within this study, it is apparent that nurses do not have the prerequisite skills required to deliver nursing care to this cohort of patients, irrespective of their level of commitment to undertake the nursing role. Rebair and Hulatt (2017) concur with this in a study conducted in the UK, indicating most respondents had never received training related to suicide prevention and awareness either pre-registration or post-registration career.

Within the care environment construct, this organisation has very clear governance structures, but continues to reinforce a culture of risk mitigation that impacts on the delivery of nursing care. Whilst individuals' beliefs and values of nurses have not been explicitly explored in this study, the senior nurses' expectations indicates that they believe nurses want to care, but are impacted by their anxieties. Inferences may be drawn that patients would be dissatisfied with the nursing care received, as it is minimalistic at best and tokenistic at worst.

The literature has for many years recognised various types of emotions experienced by healthcare clinicians when providing care for people following a suicide attempt (McAllister et al., 2002). This ranges from frustration, anger, resentment and fear. These emotions result in blaming, disengagement, withdrawal of care and purposeless activity. An underpinning tenet to these emotions and subsequent actions is that of anxiety, and this is related to the concern that a patient may attempt suicide in their ward and on their shift.

Suicide anxiety experienced by nurses caring for people following a suicide attempt is similar in nature to that of death anxiety where it contributes to negative perceptions of people in their care and is commonly experienced by health workers (Sharif Nia et al, 2016). Similarly, death anxiety experienced by nurses evokes the same concerns as does suicide anxiety. This is evidenced by nurses' reports of not knowing what to say, avoidance (Peterson et al, 2010a & 2010b; Brady, 2015) and poor or inadequate communication (Brady, 2015). The definition of suicide anxiety differs from that of death anxiety, which occurs when a person, recognizing their own humanity, experiences and exhibits emotional responses (Brady, 2015). Whereas, we offer this definition of suicide anxiety: *a circumstance in which individuals recognise the potential death of another person by their own hand and experiences resultant conscious or unconscious emotions and reactions.* Anxiety arises because there is very little that is predictable when confronted with suicidality. Compounding anxiety is the subtle recognition that the nurses themselves may be vulnerable to experiencing suicidal ideation during their lifetime.

Anxiety, in the form of work-related stress amongst nurses results in increased levels of absenteeism and reductions in quality care (Hunter, 2017). They utilize emotional energy-conserving practices such as task based nursing; superficial rather than meaningful caring relationships and display attitudes that are deleterious regarding their work and workplaces (Hunter, 2017). Emotional labour or emotional exhaustion arises when there is dissonance between the experienced emotions of the nurse, which are suppressed due to the requirements of fulfilling the role and in meeting organisational requirements (Gray, 2009; Regan et al, 2009). The tension between providing a face to the public and internalising the emotions arising from suicide anxiety increases the stressors experienced by the nurse and their ability to balance their professional role, further perpetuating these feelings and subsequent behaviours. Perceptions of time pressures and the subsequent burden to appropriately respond to patient who exhibit both physical and mental health issues often results in nurses focusing on the completion of tasks over holistic care (Harrison & Zohhadi, 2005). Busy ward environments and purposeless activity contributing to decreased time available for patients have long been linked.

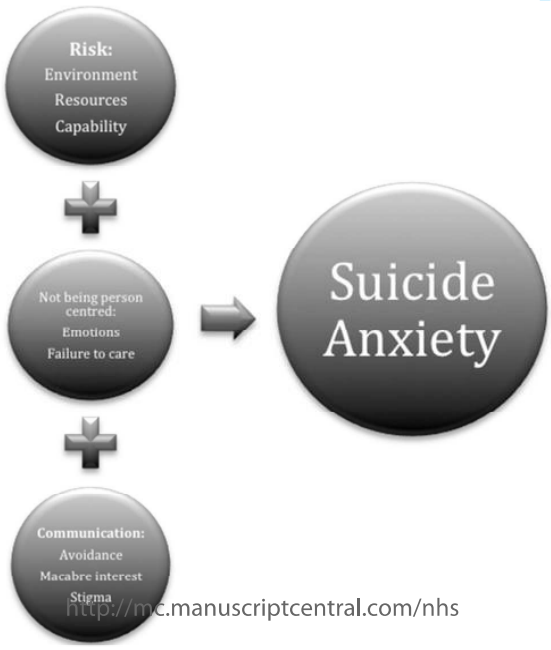

Figure 4 Suicide anxiety

Suicide anxiety as depicted in Figure 4, is represented as a complex interplay of factors, each of which is required for this to occur, arising from the individual recognizing another's potential mortality at their own behest, causing emotional reactions that occur overtly or covertly. We propose a number of factors that coalesce to drive suicide anxiety: risk, comprising environment, resources and capability, not being person centred, comprising emotions and failure to care and communication, comprising avoidance, macabre interest and stigma. Suicide anxiety causes nurses to engage in emotional, social and behavioural avoidance. By deliberately or subconsciously circumventing care, nurses perpetuate the cycle of suicide anxiety, consequently creating a paradox by behaving counter-intuitively to the 'caring' ethos of nursing work. As the avoidance of the situation progresses over time, the degree of associated anxiety increases each time the nurse is required to provide care to someone following a suicide attempt.

Horton-Deutsch & Sherwood (2017) have acknowledged that nursing is an emotionally demanding profession, compounded that it has long been recognised within the literature that lack of education and professional development contributes to difficulties faced by nurses when caring for people following a suicide attempt (Sun et al., 2011). It is incumbent upon nurse leaders to ensure efforts to counter these negative issues are implemented. The authors recommend the introduction of an anxiety ameliorating approach to nursing education and professional development. This approach must comprise of elements enabling resilience building capabilities, emotional intelligence and mindfulness, all of which will lead to greater awareness of managing suicide anxiety (Wang et al., 2016).

Limitations

This qualitative study explored the perceptions of sixteen senior nurses in a large health service in Melbourne, Australia. Consistent with qualitative research, the small sample size and subsequent findings are not intended to be generalized as they cannot be determined to be the truth as experienced by all senior nurses. However, others reading this paper may relate these findings with their own experiences and perceptions.

Conclusion

Nurses can only help others if they, themselves are in a position to help (Santa Mina et al, 2009; Meadors & Lamson, 2008). Whilst they may be in a profession that places them in positions to help others, nurses need to have the clinical support, personal strengths, resilience and opportunity for reflection on their own practice and personal beliefs, in order to provide the nursing care required for such difficult situations.

In addition, they require suicide attempt aftercare educative and emotional support as well as education regarding mental health care including, for example, mental state examination, risk assessment, risk management and clinical supervision. It is important that nurses gain an understanding of the impact of suicide anxiety as it has a direct correlation to the care and wellbeing of a person who has attempted suicide as well as to their own resilience and wellbeing.

The findings of this study can be presented as multiple principles made up of elements that collectively form as not being person centred, risk and communication, and where

suicide anxiety is the central tenet underpinning these premises. The interviews provided an abundance of rich commentary regarding the nurses who provide suicide attempt aftercare in the wards of their hospitals. It is evident that these senior nurses perceive that many nurses do not have the requisite knowledge and skills when providing care to this cohort. Compounding these deficits is the emotional burden placed on the nurse when caring for these people. It is the expression of this lack of knowledge, skills and emotional responses that exhibits as attitude and subsequent behaviour.

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Paper Two: Consumer perspectives of medical/surgical nursing care following a suicide attempt

Submitted: Nursing and Health Sciences

Abstract

This study involved exploring insights of consumers into their care experiences and expectations of medical/surgical nurses following a suicide attempt. The literature reports chiefly upon the attitudes and behaviours of nurses who provide this care. Little is known whether general nursing care provided to people who have attempted suicide meets consumer expectations. This qualitative study was conducted across three metropolitan hospitals in South Eastern Melbourne, Australia. Data was collected between February and May 2017. In total nine interviews were conducted with consumers who had been admitted to general medical/surgical wards following a suicide attempt. The interviews were audio recorded and subjected to van Manen's thematic analysis. Two main themes emerged from the data: Needing to protect and facing blame. There were secondary aspects: for nurses, for themselves and internal and external. Consumers who are admitted to general hospital following a suicide attempt do not expect the nurses there to be able to assist them in their recovery. Generalist nurses need to upskill in order to be able to provide the nursing care required of people who attempt suicide.

Key words: consumer, nurse, suicide attempt, general hospital

Introduction

Suicide is an international health issue responsible for the deaths of over 800,000 people annually (van Landschoot et al, 2017), with the World Health Organisation estimating that for each death by suicide there are twenty attempts (WHO, 2014). Those who are injured during a suicide attempt are likely to receive care from, and interact with nurses in medical or surgical settings and are likely still be suicidal (Lakeman, 2010). Of interest then are the experiences of the people as recipients of medical/surgical nursing care following a suicide attempt. Contemporary suicidology focuses research primarily examined within the epidemiological domain, addressing issues of risk factors, symptomatology and demographic data sets (Fitzpatrick et al, 2015; Kral, Morris & White, 2017). However, proponents of critical suicidology recognize that this nomothetic focus limits the understanding inherent within individuals of their own experiences (Fitzpatrick et al, 2015; Kral, et al., 2017). There has been a long history of qualitative research undertaken within the field of suicidology, however much of these biographies, letters, suicide notes and diaries are subjected to quantitative analysis (Fitzpatrick et al, 2015). People are the experts of their own experiences and it would be remiss to consider the provision of suicide aftercare without engaging with them. We use the term consumer to describe any person receiving nursing care following suicide attempt.

Background/ literature

In Australia, there are national mandated standards for health care providers that must be achieved in order to secure compliance with the regulatory authority (ACSQHC, 2011). According to Australian Commission on Safety and Quality in Healthcare (ACSQH) of the ten national standards developed, Standard 2: Partnering with Consumers, "describes the systems and strategies to create a consumer-centred health system…" (ACSQHC, 2011, p3). Most importantly, consumer participation is one way that health services strive to provide safe care and attain quality improvement. The ACSQHC considers consumer participation as a vital role in informing service development, models of care, gauging service and in the evaluation of systems (ACSQHC, 2011).

Accessing consumer perspectives to improve quality outcomes is not limited to Australia. The Patient Experience Library from the United Kingdom (2017, p3) indicates the importance of including the patient experience and quotes Lord Darzi, "If quality is to be at the heart of everything we do, it must be understood from the perspective of patients", with some proponents including patient participation as an essential element of modern healthcare practices (Thórarinsdóttir & Kristjánsson, 2014). This shift from paternalistic oversight to a more inclusive, shared approach to decision making has arisen from the consumer driven movement ensuring that individual rights are considered (Thórarinsdóttir & Kristjánsson, 2014). Including consumers who have attempted suicide is an opportunity to acquire beneficial and relevant data informed directly by their own experiences (Ghio et al, 2011). Globally, the voice of the consumer perspective or lived experience of suicide is considered essential in research, strategy development and advocacy and vital for the progression of suicide prevention strategies. Suicide Prevention Australia (SPA), a national peak body whose focus is on reducing suicide have formally adopted a number of principles ensuring that the lived experience and consumer voice is actively sought because of the value it holds within the domain of suicide prevention. However, the Department of Health (UK) in 2001 reported that the concept of recognising patients as experts of their own experience has been largely overlooked, with clinicians considering the consumer voice to lack authority subsequently disregarding their experiences (Department of Health, 2001; Ghio et al, 2011).

Additionally, accessing the consumer voice by engaging consumers in suicide research often meets ethical stumbling blocks or barriers (Hom et al, 2017).

Aim

The aim of this study was to explore the lived experience of consumers receiving care from nurses in medical/surgical wards following a suicide attempt.

Methods

Design

The authors conducted a qualitative study using semi-structured interviews in order to ascertain their perceptions of the way in which nurses on these wards provided care.

Inclusion criteria

In order to be eligible to participate, participants had to be aged over 18 and attempted suicide, requiring admission to a medical or surgical unit for physiological treatment. The consumers interviewed were all admitted to one of six general medical/ surgical wards of a major metropolitan health service comprised of multiple hospitals across various campuses in southeast Victoria, Australia.

Data collection

The Nurse Manager of the wards notified XX of any potentially eligible participants who had been admitted. XX subsequently attended the ward to meet the potential recruits and advise them of the study. The interviews were conducted by one researcher (XX) within the admitting wards within private rooms or offices. Based on the literature and clinical experience of the researchers (XX, YY & ZZ), there were five indicative questions developed and asked of all participants. All participants were interviewed on a single occasion. The interviews were conducted from February to May 2017. The interviews were digitally audio recorded enabling verbatim transcriptions to be written as text.

Interviews are conducted in order for researchers to garner comprehensive discourse providing a rich source of data for analysis and recognition of the unique perspectives of individuals (Koshy at al, 2011). Semi-structured interviews require the development of a set of pre-determined questions to ensure constancy between interviews, however they also provide the opportunity to ask probing questions in order to elicit more information from the participant's initial responses (Koshy et al, 2011; Minichiello et al, 2004).

Sampling

Universal purposive convenience sampling was adopted and all people meeting the criteria and who were admitted during that time were invited to participate (Schneider, Whitehead, LoBiondo-Wood & Haber, 2016). All agreed to participate (n=9). Those admitted and who consented were approached by the Champion and invited to participate. XX was notified. At interview, the ability to consent according to the Evaluation to Sign Consent (ESC) Protocol was determined. The ESC protocol is a five-item questionnaire designed to establish potential participants' ability to understand information relevant to the study and expectations of their participation (DeRenzo et al, 1998). Following consent, the interview proceeded. No payments were offered for participation.

Role of the researchers

The investigatory team comprised three researchers, all female, with one researcher, conducting the data collection (XX). XX is a registered nurse with specialist mental health

nursing and suicidology qualifications and at the time employed as a Director of Nursing within the healthcare organization. She also holds an adjunct position with organization's affiliated university and was in the process of completing her PhD. The two researchers who aided in the research design and data-analysis (YY and ZZ) have both obtained their PhD and specialist mental health qualifications. As both nurses and academics, they are experienced nurses with vast experience in qualitative and mixed methods research.

Data analysis

The interviews were transcribed verbatim from audio recordings and analysed using van Manen's thematic analysis (van Manen, 2016). Consensus about themes was reached during collaborative sessions amongst the researchers, with divergences resolved through discussion.

The thematic analysis consisted of the methods indicated by van Manen's approach of three undertakings. The first undertaking is the wholistic [sic] approach, whereupon the transcripts are read in their entirety and try to capture the meaning and significance as a whole (van Manen, 2016). The second undertaking is the highlighting approach, where the transcripts are read repeatedly in an attempt to highlight aspects of the text that are considered to be an essential part of the phenomenon under study (van Manen, 2016). The third and final undertaking is the detailed reading approach where individual sentences are reviewed pending revelations about the phenomenon under study (van Manen, 2016). Each of these undertakings combined inform the themes present within the text.

Ethical considerations

The healthcare organization's Human Research and Ethics Committee – B (HREC-B) approved the study, with university endorsement. Permission to conduct the study in the relevant hospitals and wards was obtained from the appropriate Directors of Nursing. Participants were provided with a full explanation of the study and informed about the dual role of the researcher conducting the interviews (XX). They then provided written consent to participate, followed by verbal consent for the audio recording. All participants were notified that their identity was protected through use of pseudonyms.

In order to establish consumer capacity to consent in this study, the ESC protocol was enacted (DeRenzo et al, 1998). The ESC protocol is a five-item questionnaire designed to establish potential participants' ability to understand information relevant to the study and expectations of their participation (DeRenzo et al, 1998).

Demands to include qualitative methods within the domain of suicidology have been met with a tempered response, often as a result of ethics committees concerns about risk (Lakeman and Fitzgerald, 2009). However, in order to progress the knowledge base of this domain, the exclusion of those considered to form part of a vulnerable population limits development of knowledge and may also be considered to be unethical (Mishara & Weisstub, 2005). In order to assure the ethics committee of the researchers' commitments to participant safety was the inclusion of a rescue procedure (Mishara & Weisstub, 2005), however within this study this was termed an intervention procedure because of the connotations that rescue implies a sense of hopelessness and non self-determination. Debriefing is an essential activity to be undertaken when research occurs in topics of a sensitive nature. Participants were provided the opportunity to debrief with the interviewer (XX) at the completion of the interview. XX was also provided opportunity to debrief with the other researchers (YY&ZZ).

The design and implementation of this study was informed using the Consolidated criteria for Reporting Qualitative studies (COREQ) checklist (Tong et al, 2007). The COREQ is a 32 item checklist that aids researchers in the development of a structure with which to

comprehensively report on findings arising from qualitative research, including but not limited to interviews (Tong et al, 2007). Each item has been categorized into one of three domains; investigation team and reflexivity, study design and analysis and findings (Tong et al, 2007). An essential element of qualitative research is the narratives and stories that are derived from the investigation.

Findings

Participants

There were nine participants, four female and five male. They ranged in age from 34 to 72 years. Two participants did not have English as their first language (Singhalese and Arabic). None openly declared and identification as Aboriginal or Torres Strait Islander. Methods of suicide attempt were not actively sought during the interview, however some participants voluntarily disclosed their method (overdose, hanging, carbon monoxide poisoning). Two participants were referred for admission to mental health inpatient units for follow up. The remainder were discharged to their usual residence. Only one participant was seriously physically compromised requiring Intensive Care prior to admission to the medical ward and subsequent mental health inpatient referral.

Whilst all participants had unique experiences, some shared experiences emerged. The major themes that arose from the interviews were: need to protect and facing blame (Table 1 and Table 2).

Table 1: Major themes

Main themes	Aspects
Need to protect	For nurses
	For themselves
Facing blame	Internal
	External

Table 2: Participants and themes

	Themes			
Participants	**Need to protect**		**Facing blame**	
	For Nurses	**For Themselves**	**Internal**	**External**
1				
2				
3				
4				
5				
6				
7				
8				
9				

Need to protect

Participants in this study identified two aspects of protection: for nurses and for themselves.

They recognized that the nurses were not specialist mental health nurses, so subsequently did not raise or discuss the issues that led to them being admitted to hospital.

> *I don't talk to the nurses about suicide. I wouldn't want to burden them. They are all great, but don't know about risk – Troy*

Nevertheless, Troy indicated that he was concerned about his ongoing safety on the ward and in order to minimize his risk without exposing the lack of knowledge of the nurses placed his hooded jacket that contained drawstrings (hoodie) in the back of his wardrobe in order to distance himself from the temptation of further self harm. At the completion of the interview, he requested that the researcher approach the nurse caring for him to request that the drawstrings be removed from his clothing, and to make it appear as though it was the researcher's suggestion. This was important to him, as he did not want the nurses to feel as though he was criticizing them.

All the participants were expected to wear their personal attire whilst other patients were expected to wear hospital attire. Participants were unclear as to the reason for this demarcation. It appears that wearing one's own clothes signifies a lack of acknowledgment of the sick role by nursing staff. For example, Troy indicated that he was the only patient on the ward dressed in day clothes. As a result, some of his co-patients had enquired as to the reason for his admission, highlighting the differences between suicide attempters and others requiring hospitalisation.

Troy also relayed his experiences of what brought him to hospital and whilst he did not engage with the nurses about his mental health care, he acknowledged that they provided him with the physical care he needed in order to commence his recovery. They also treated him with respect.

> *It's not my first time. I just get stuck with where I am. I've been using [drugs] and got homeless. I've been living on the streets. When I came in I was filthy, hadn't been wearing shoes and had lice. The nurses cleaned me up and didn't look at me like I was nothing – Troy*

Raj was the participant with the shortest interview time, he did not expound on his answers, instead rushed through the interview. He utilized circumlocution potentially to distract from the real reason for his admission, preferring to focus on the physical outcome rather than the underlying mental health cause, perhaps with the aim of protecting himself from further embarrassment and protecting the nurses from criticism. He quickly stated that the nursing care was satisfactory and indicated that he was treated by the nurses *"just like everyone else".*

Participants were of the view that the nurses did not have the mental health skills and knowledge to support them and were instead anticipating that their mental health care needs would be met when they were transferred to the specialist inpatient mental health units.

> *They can't do anything for me. The past can't change, so why discuss it? I'm going to the psych side soon – Tina*

> *I will talk to the psych nurses when I get transferred there. I'm going today. They know what to do and I feel safe there – Troy*

Additionally, Troy stated that he had been educating some of the patients co-located in his four-bed bay as to his, and others, potential reasons for attempting suicide. He felt more comfortable discussing his suicide attempt with them than with the nurses.

Concern for the nurses and perception of adding to the workload as well as the increased burden of care meant that some participants did not engage with their nurses.

> *I don't want them to worry about me. They are busy and I don't need much – Elsie*

Facing blame

The authors have interpreted the theme of facing in terms of two components: internal and external. Internal blame relates to the emotions and thoughts experienced by the consumers as a result of the circumstance surrounding their admission. Whilst external blame is the representation of attitude directed at consumers from nurses. Blame is associated with feelings of guilt, censure and culpability.

All participants were aware that the interviewer conducting the interviews was cognizant of the reason for their admission. However, one participant when asked whether he felt comfortable talking with his nurse about his suicide attempt, responded that he had fallen from a ladder. His suicide attempt was in the context of a social crisis where he had overdosed on insulin.

One participant relayed her experiences of being transferred to a medical ward from the Emergency Department, where she overheard the nurse discussing her admission and used the term "…she's been a naughty girl". She experienced both internal and external blame, where the nurse trivialized her attempt and she herself castigated her own behaviour.

> *I was thinking…how does such an attitude exist? Are behaviours of patients to be viewed in light of needing punishment? Is it that the person (i.e. me) has done something wrong, or is it that they have done something wrong in the eyes of someone else, perhaps God? Why is it then, that someone who has survived a possible (admittedly by self choice) death is faced with judgement and discrimination? What was I thinking? How selfish, self-indulgent, seeking of attention, weak – Sharon*

Nevertheless, Sharon was also able to articulate the positive outcome for her when interaction with a nurse who was empathic and respectful and authentic.

> *Today I met an angel. I felt she was sent to me. She was gentle and kind and softly spoken and gave me strength. Strength to move on...to know I must do this myself but that I had friends and support to help me through - Sharon*

One participant was either unable to speak positively about her experiences of nursing care or she had devalued herself as a person because of her suicide attempt when asked about the care she received she rebutted with the statement "*I'm just a silly old woman" – Elsie.*

Discussion

This study sought to explore the lived experience of suicide attempters and their perceptions of the nursing care they received in the medical ward. It appears in this study that the participants were aware of the lack of capability of the nurses and had low

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Discussion

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expectations regarding the care they would receive. This was expressed in the form of not wanting to burden the nurses or to find fault with their practice.

Whilst hospitalized following a suicide attempt, people may receive the treatment required for their physical ailments, however the psychological aspect of care is often overlooked (Guptill, 2011). This in part may be due to lack of education they receive regarding suicide awareness and prevention, with only 28% of respondents of a Royal College of Nursing survey affirming that they had received education in these domains (Rebair & Hulatt, 2017). Within the same study, concerns of not knowing what to do, not having adequate knowledge to help and time limitations were considered to be barriers to nurses engaging with patients about their suicidal ideations (Rebair & Hulatt, 2017). Within the early days of suicide attempt aftercare, the quality of the therapeutic alliance has been highlighted as extremely important (Frei et al, 2012). It is recognized that without the development of a trusting and helping relationship from the outset, the prospect is that of lack of engagement (Frei et al, 2012).

The participants in this study had mixed experiences regarding the level of empathy and compassion from nurses. However, the positive experiences were generally related to the nurses addressing physical aspects of their care, not specifically associated with their mental state.

While the nurse may not understand the person's reasons for attempting suicide, they should be able to respond with carefully chosen words and portray thoughtfully and sensitively that the consumers have been provided with the option to look for a more healing approach to their situation (Santa Mina et al, 2009). The combination of empathy and compassion; considered to be essential elements of the nursing process, provides a space for discourse to occur where people feel safe from judgement, criticism or abandonment (Cooper & Sawaf, 2000). An inability to provide care that is motivated by empathy and compassion indicates the likelihood of negative attitudes towards the person who has made a suicide attempt (Keogh, Doyle, & Morrissey, 2007). Not only does lack of knowledge by clinicians impact upon the care and attention suicidal people receive, but so too does the attitude of the clinicians (Saigle, 2016). Self-reflection that leads to greater self-awareness can enhance opportunities for individuals to consider their own attitudes and subsequent care responses (Talseth & Gilje, 2011). Nurses, like other professionals, are influenced by sense of self and therefore bring these perceptions and attitudes to work (Santa Mina & Gallop, 2009). These influences may be positive or negative in relation to the effect of the innate behaviours of the nurses and may have direct or indirect implications regarding the level of care provided to people (Stein-Parbury, 2009; Talseth & Gilje, 2011). However, some nurses report that having experience with suicide assists them in their ability to discuss these issues with patients (Rebair & Hulatt, 2017).

All the participants in this study demonstrated to various degrees, shame and guilt concerning their suicide attempt and their overall personal circumstances. As a consequence, they sought to shield nurses and themselves from further humiliation and embarrassment.

Shame is an emotion experienced by many people in the aftermath of their suicide attempt (WHO, 2014; Berg et al, 2017) and may explain why one participant dismissed the real reason for his reason for admission to hospital. Shame also carries with it, a sense of isolation and demoralization (Clarke & Kissane, 2002) subsequently increasing the risks of further suicide attempts (Vatne & Nården, 2014). Feelings of shame can potentially be

moderated through the meaningful engagement between nurses and consumers (Vatne & Nården, 2014). However, these emotions can be further exacerbated by negative attitudes of the nurses caring for them (Wiklander et al, 2003). The negative attitudes of the nurse may be overtly displayed as rejection or avoidance to the point of hostility directed at the individual (Doyle et al, 2007). A consumer's self worth may also be negatively impacted because a suicide attempt, as well as requiring help may be perceived as a personal failure (Vatne & Nården, 2014). Feelings of shame and perceived or internalized stigma may also impinge upon the individual's coping resources and exacerbate feelings of hopelessness, subsequently leading to increased feelings of suicidality (Scocco et al, 2016). Internalized stigma refers to the perceptions of consumers when they consider, believe and apply to themselves, the potential stereotypical thoughts and behaviors of others (Drapalski et al, 2013). Additionally, internal stigma exacerbates feelings of shame, further increasing the risk of suicide (Oexle et al, 2017). It is known that people who experience high degrees of internalized stigma often conceal their suicide attempts (Carpiniello & Pinna, 2017).

Being cared for in an environment not suited to the mental health needs of people increases their sense of isolation and risk, with participants stating that irrespective of the caring environment they experienced a sense of suffering and desire to be protected from themselves (Berglund et al, 2016). Whilst some participants received 1:1 nursing supervision as a risk mitigation strategy, medical/ surgical wards are inherently unsafe environments for the suicidal person (Chan et al, 2008). Notwithstanding the lack of an adequate knowledge base and skill level of nurses, the increased supervision experienced by some participants who were also able to describe their nurses as caring, provides a safety net and acts as a deterrent against suicidal behaviour (Berglund et al, 2016).

Relevance for Clinical Practice

Due to the mixed experiences of participants and their assumptions regarding nursing care, it is recommended that nurses have the clinical support in order to provide the nursing care required for such difficult situations. Personal resilience and the opportunity for reflection on their own practice and personal beliefs is fundamental to the therapeutic relationship. These self-care activities need to be incorporated into training and life-long professional development as they are known to balance workplace emotional effects. The opportunity for cathartic release in a supportive manner is essential for nurses to provide holistic care to consumers. It is recommended that nurses in the acute sector have access to clinical supervision as a means to reflect and enable emotional equilibrium.
In addition, specific contemporary training in suicide and suicide prevention needs to be frequently offered to nurses by health services in order to build their confidence and competence in providing care to people following a suicide attempt.

Importantly, positive interactions and the use of the therapeutic relationship to develop trust must be valued by nurses. Participants in this study attempted to shield nurses to avoid further embarrassment and stigma, despite them possibly remaining at risk of suicide. The ability to acknowledge and validate feelings and a willingness to hear the person's story is fundamental in providing suicide attempt aftercare.

The knowledge and skills required to provide this level of care is likely to require significant investment in education and professional development of nurses. It is incumbent upon universities and education providers who deliver academic content to nursing students, either as undergraduates or post graduates to include the provision of suicide intervention and post-vention within their programs. It is also incumbent upon health services to provide

ongoing professional development regarding suicide and provide access to clinical supervision for nurses to reduce stress.

Limitations

This qualitative study explored the experiences of nine consumers in a large health service in Melbourne, Australia. Consistent with qualitative research, it is not intended that one could draw general inferences from the small sample size, however this paper may uncover some transferability of the findings to discover relevance with others' opinions and experiences. One of the researchers (XX) was a Director of Nursing within this health service, however held no operational responsibility for the areas where the research was conducted. This study formed part of her Doctoral studies and as such was incumbent to undertake the data collection.

Conclusion

A suicide attempt causes significant distress for the person and others including discomfiture, shame and remorse. Consumers did not express dissatisfaction with the nursing care they received, however, expectations of their nurses' abilities to assist them beyond that of physical health care during times of crisis was limited. It is important that nurses gain an understanding of the impact that they can also have on the care and wellbeing of a person who has attempted suicide. It is essential to ascertain consumer perspectives and experiences of the nursing care received in order to be able to inform the workforce and establish educative programs to redress gaps in knowledge and skills. These perspectives also allow for understanding of the thoughts and emotions experienced by people receiving suicide attempt aftercare as they may provide insight into additional risks and subsequent suicidal behaviour.

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Chapter discussion

As the most trusted occupation, nurses are often identified as their profession role and not as people inside the uniform (Girvin, et al., 2016). Patients expect that the care they receive is the best, with apparent little regard for what it takes to deliver such care or how a nurse learns to exhibit the qualities needed for suicide attempt aftercare. As human beings, nurses are as fallible as anyone else (Stein-Parbury, 2014). However the risks and outcomes of these fallibilities may have more serious consequences than for other professions. Illness, distraction, tiredness, stress and family issues are some of the factors that negatively interplay with care delivery (Stein-Parbury, 2014). Nurses not only identify with being a nurse, but also mother/ father, wife/ husband, daughter/son, friend, colleague. These other roles however, are not the ones that patients see and so expect nurses to be everything to them.

Anxiety

Anxiety, in the form of work-related stress amongst nurses results in increased levels of absenteeism and reductions in quality of patient care (Hunter, 2017). This is because they utilize emotional energy conserving practices such as task based nursing, superficial rather than meaningful caring relationships and attitudes that are deleterious in nature regarding their work and workplaces (Hunter, 2017). In her seminal work regarding nursing and anxiety, Menzies Lyth (1959, 1961, 1970) acknowledged that nursing is inherently anxiety inducing and that nurses develop techniques in order to manage the anxiety. When under threat, from their experiences of anxiety, the nurse's ego seeks to

protect itself, through mainly unconscious means, known as defense mechanisms. The ego shields itself through the fantasies and defenses typically indicative of early nurturing relationships (Holden, 1991). These are manifested as denial, projective identification and splitting and is due to the association with nursing as a caring profession. Gates and Gillespie (2008) identify both avoidant and numbing responses as psychological defenses. Defense mechanisms are unconscious mental processes aimed at protecting the individual by reducing internal conflict caused by anxiety arising from a variety of both internal and external stimuli (Cramer, 2006). These various types of defense mechanisms are manifested by a number of behaviours such as purposeless activity, avoidance, negative self-talk withdrawal, lack of engagement, anger and irritability and of emotional reactions such as fear (Regan et al, 2009). All of which are seen in nurses who provide care to people post suicide attempt. Beck (2011) identifies a number of coping strategies employed by nurses when faced with stress and distress, including sustaining a sense of humour and positive attitude, access to and attendance at debriefing and individual awareness of triggers. These may aid in circumventing the initiation of defense mechanisms.

Anxiety is also derived from the nurse-patient relationship due to the rapid and persistent turnover of people either via death, discharge or transfer. Death and loss are frequent occurrences to which nurses are exposed, and ones that nurses' rely upon denial to deal with (Menzies Lyth, 1959, 1961, 1970). These repetitive and short relationships do not permit nurses to establish the appropriate emotional attachment or boundaries required in order for them to feel safe and to provide nurturing care. The recognition that the closer the working

relationship of the nurse-patient is, then anxiety becomes the primary driver of behaviour, one managed through reducing contact and adhering to task lists (Hill, 2010; Menzies Lyth, 1988; Hunter, 2017). Additionally, people are also often labeled as 'good' or 'bad' as a way of objectifying them, rather than viewing them as people needing care (Holden, 1991; Pompili, 2006).

Malone (2000) reports that task oriented nursing is a way of protecting the nurse from engaging with people at their most vulnerable, subsequently avoiding the anxiety that this provokes. Concentrating on tasks enables the nurse to focus on the details of the activity rather than the feelings that are associated with the person (Hill, 2010). Additionally, Thorup, et al., (2012) believe that nurses' managing their own emotions is an integral component of being able to provide for the patient. When discussing self-mastery competencies, Goleman (2011) believes that the ability to manage one's own emotions and achieve goals because of a relentless focus, adaptability and initiative are integral aspects of emotional intelligence. Each of these competencies form essential criterion for nurses and nursing.

Stigma

People are vulnerable simply by being in the role of patient within the nurse-patient relationship. Certain patient populations exhibit more vulnerability than others and this in particular, includes those who have attempted suicide. Stigma has for a long time been viewed as a negative driver of behaviour towards people with mental illness. It is exhibited through exclusion, labeling, blaming and using judgemental language. People receive treatment that instead of being compassionate could be viewed as punitive (Epstein & Olsen, 2007). These

outcomes are similar in nature to those expressed in the literature regarding attitudes to suicide (Anderson, Standen, & Noon, 2003; Doyle, Keogh, & Morrissey, 2007; Gibb, Beautrais & Surgenor, 2010; McAllister, Creedy, Moyle & Farrugia, 2002; Talseth & Gilje, 2011; Vivekananda, 2000). It then becomes clear that there is a connection between stigma and suicide anxiety in that the anxiety experienced by nurses' exhibits itself through the guise of stigma.

Suicide anxiety

Suicide anxiety as depicted in Figure 7, is represented as a complex interplay of factors, each of which is required for this to occur, arising from the individual recognizing another's potential mortality at their own behest, causing emotional reactions that occur consciously or unconsciously. Suicide anxiety causes nurses to engage in emotional, social and behavioural avoidance. By deliberately or subconsciously using avoidance, nurses perpetuate the cycle of suicide anxiety, consequently creating a paradox by behaving counter-intuitively to the 'caring' ethos of nursing work. As the avoidance of the situation progresses over time, the degree of associated anxiety increases each time the nurse is required to provide care to someone following a suicide attempt. Suicide anxiety explains not only the avoidance or provision of minimalistic care, but also the barriers to engagement, knowledge deficits, fear, frustration, hostility and anger. Additionally, avoidance is compounded by guilt and can be likely attributed to not having the confidence and skills to provide care to this patient group. Some nurses shy away from caring for people who are suicidal because they are culturally confined from acknowledging and discussing suicide (Jones et al, 2015). The complexity of caring for a person following a suicide attempt is

compounded by concerns about the risk these people present and the capabilities of the nurses. Additionally, capability, communication and stigma also combine to contribute to suicide anxiety by objectifying these individuals. These confounders are managed through avoidance and requests for provision of additional staffing resources. Macabre interest is manifested by the over inclusiveness of information, particularly during handover. Whilst stigma influences the desire to have mental health specialty involvement to the extent of abrogating responsibility for the patient and increasing ward busy work.

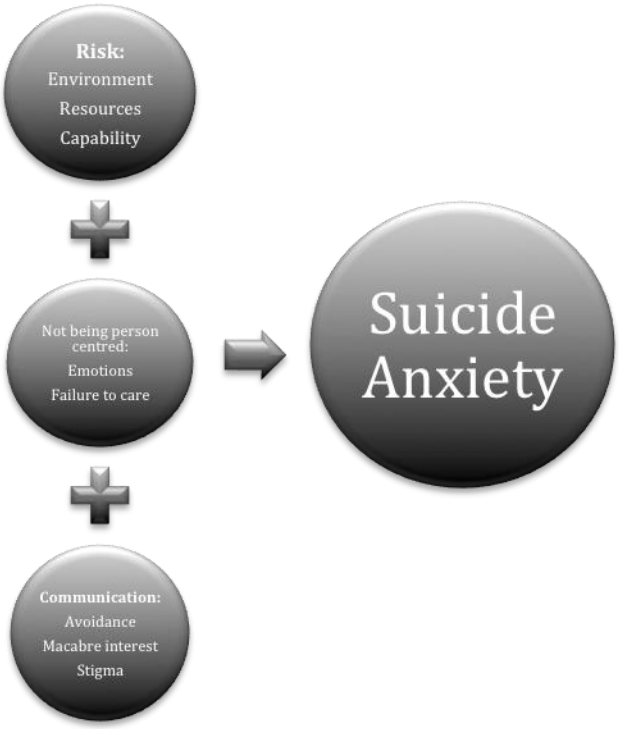

Figure 4.1: Suicide anxiety

Professional development

It is evident from the senior nurses that they perceive that many nurses do not have the requisite knowledge and skills when providing care to this cohort. Compounding these deficits is the emotional burden placed on the nurse when

caring for these people. It is the expression of this lack of knowledge, skills and emotional responses that exhibits as attitude.

The profession of nursing undergoes significant and rapid change on a constant basis. This is due, not only to technological advancements, but also mandates for change that are attributable to reviews, reports and standards of practice (Hughes, 2008; Levett-Jones, 2005; Scott, 2008). In order to ensure that nurses are able to practice within the bounds of contemporaneous knowledge and skills they are required to participate in continuing professional development. Many consider continuing education to be an essential element in ensuring that nurses are suitably skilled and able to deliver quality and safe patient care over the course of their career (Levett-Jones, 2005; Malik et al, 2015). However, nursing education is often focused on those nurses in their early career, with newer nurses requiring orientation, induction and competency-based assessments (Jarvis, 2005; Levett-Jones, 2005; Malik et al, 2015). Often overlooked, then are the nurses for who are in the middle to latter stages of their careers (Levett-Jones, 2005). In a study conducted by Chaghari et al (2016), the authors refer to a theme of "weakness in educational management" (Charghari et al, 2016, p500) and indicate that this refers to poorly undertaken needs assessment. Needs assessments determine the focus of education that are systematically scheduled, developed and implemented and are considerate of adult learning theory (Chaghari et al, 2016; Jarvis, 2005). It is important to consider that any educational activity is designed with outcome goals, including that of knowledge and skill enhancement (Pilcher, 2016). They should also contribute to enhancing patient outcomes and the delivery of care that is sustainable (Pilcher, 2016).

Suicide attempt aftercare educative support as well as education regarding mental state examination, risk assessment, risk management and clinical supervision is essential ongoing learning for nurses.

Provision for education that extends beyond the designated education calendar is considered onerous for staff on the ward to participate in. Formal education sessions delivered twice a week do not capture the entire nursing workforce, nor do they meet the needs of nurses with knowledge and skills gaps. Requests for and access to education regarding suicide and attempted suicide is not always facilitated, because it does not fit into the schedule. Rebair and Hulatt (2017) recommend that health services facilitate the provision of education about suicide utilizing a variety of formats including e-learning, workshops, seminars, shadowing and shared practice. There are nurse researchers who advocate for educational standards about suicide to be established and the provision of education on this topic to be mandatory for all nurses (Bolster et al, 2015).

There is a requirement that nurses deliver care that is holistic and person centred. Interestingly, some senior nurses indicated that it was easier to provide care for people when you can see the need for the care, as in the case of people requiring physical interventions and hands on care. One respondent in a Royal College of Nurses study stated that before commencing the survey they had not considered their lack of knowledge around suicide as a knowledge deficit and one that required additional education (Rebair & Hulatt, 2017). This unrecognised knowledge deficit may confound the notion of the nurses' ability to prioritise the patient's need for care. Nursing prioritization arises from the ability to establish patient needs and goals of care (Lake et al, 2009). Where

knowledge deficits are a confounder, nursing care cannot be delivered in a meaningful way to patients who have unrecognized and subsequently unmet needs, which in turn leads to not being person centred.

Person Centred Care (PCC) is proven to enhance outcomes for patients with improvements in patient experience being linked directly with high quality and safety (Edvardsson et al 2016). PCC ultimately aims to connect the task-based activities of nursing with the human component of care provision and connectedness to ensure that the individual is not lost in the myriad of action that occurs within health (Edvardsson et al, 2016). PCC adopts the 'do with, not to' mantra that assures patient dignity and rights are upheld. Person-centred care is a partnership of care delivery and care outcomes (Ghebrehiwet, 2011). In order to deliver PCC, nurses must act in a compassionate manner enveloped within a trusting, nurturing relationship conveyed with respect (Feo et al, 2016).

Because of the nature of the relationship between the nurse and the patient, with the patient receiving care for medical reasons, it is possible to 'lose' the person within and focus on delivering patient focused care (Buetow, 2011) rather than person-centred care. The term patient implies that the person has an issue to be treated or managed whilst person refers to the human aspect of being. These are not interchangeable terms. Nursing has long held the perspective that patients are viewed holistically (Bagdonaite-Stelmokiene et al, 2016; Ghebrehiwet, 2011), as one whole body, comprising a myriad of smaller components each of equal value. Barriers to person-centred care arise when nurses are unable to view patients holistically because they are unable to see beyond the patient to the person (Bagdonaite-Stelmokiene et al, 2016; Ghebrehiwet, 2011). Harrison and

Zohhadi (2005) recognise the inability to provide person-centred care when patients with both physical and mental health concerns are viewed from a task focused lens due to the perception that they may disrupt the ward environment. Sun, Long, Boore and Tsao (2006) developed a conceptual paradigm for the nursing care of suicidal patients to which the core category is that of safe and compassionate care. The nursing interventions are that of providing holistic assessment, providing protection, providing basic care and providing healing (Sun et al, 2006). Nurses in a study conducted in the Emergency Department reported that their roles in providing suicide attempt aftercare was that of risk assessment, environmental safety and responding to physical health needs and not that of providing for the person's mental health concerns (Doyle et al, 2007).

Suicide attempt aftercare involves a complex interplay of nursing strategies that ultimately reside in the provision of person centredness. The basis for person centredness is the philosophical underpinning regarding viewing people as individuals (McCormack et al, 2010). Person centred care extends on this, with nurses recognising and providing for the individual needs of patients in a truly respectful manner (McCormack et al, 2010). McCormack and McCance (2006) developed The Person-Centred Nursing Framework comprising of four constructs; prerequisites, care requirements, care processes and outcomes. The prerequisite construct identifies the professional attributes of individual nurses including the requirement to be appropriately skilled and committed to undertake the nursing role (McCormack & McCance, 2006). The care environment construct refers to the organisational context to which the nursing care is being provided including having the necessary governance structures and

teams, but also includes organisational culture (McCormack & McCance, 2006). The care processes construct is indicative of the underpinning philosophy as it addresses the notion of engagement alongside recognition of individuals' beliefs and values (McCormack & McCance, 2006). The outcomes construct relates to how patients would rate their care, specifically the degree to which they are satisfied in the care they received as well as the collaborative processes that occurred throughout their patient experience (McCormack & McCance, 2006). Not being person centred occurs when there is a failing to deliver one or more of the constructs specified in the framework. Within this study, it is apparent that nurses do not have the prerequisite skills required to deliver nursing care to this cohort of patients, irrespective of their level of commitment to undertake the nursing role. Within the care environment construct, organisations have very clear governance structures, but continue to reinforce a culture of risk mitigation that impacts on the delivery of nursing care. Cooper and Sawaf (2000) write that the combination of empathy and compassion; both essential ingredients of the nursing process, encourages people to talk of their experiences whilst feeling safe from judgement, criticism or abandonment. This sentiment is echoed by Keogh, Doyle and Morrissey (2007), who report that an inability to provide this level of care may be indicative of negative attitudes towards the individual who has attempted suicide.

Risk in healthcare is often viewed negatively and something to be managed. However, the identification of risks are often a critical ingredient within quality improvement methodologies and when integrated assist in the focus of clinical practice (ACHS, 2013). In other industries risk may be viewed as opportunity.

Risk in health has become events to be avoided, with risk mitigation strategies implemented in order to prevent potential negative outcomes occurring. The potential nature of healthcare outcomes including death and disability arising from accident or neglect has led many organisations to become risk averse. Risk assessment is one component of risk management, with nurses undertaking various types of these assessments every day, ranging from falls assessments and skin integrity assessments to environmental risk assessments. The purpose of risk assessments is to determine the potential for a negative incident occurring and quantifying the potential negative outcomes. The inability to undertake suicide risk assessments by nurses means that suicide risk mitigation strategies cannot be implemented. Without truly understanding the inherent nature of risks associated with attempted suicide and the fluctuating nature of this risk, nurses are unable to provide quality and safe care.

Emotional labour or emotional exhaustion arises when there is dissonance between the experienced emotions of the nurse, which are suppressed due to the requirements of fulfilling the role and in meeting organisational requirements (Gray, 2009; Regan et al, 2009). The tension between providing a face to the public and internalising the emotions arising from suicide anxiety increases the stressors experienced by the nurse and their ability to balance their professional role, further perpetuating these feelings and subsequent behaviours. Perceptions of time pressures and the subsequent burden to appropriately respond to patient needs who exhibit both physical and mental health issues often results in nurses focusing on the completion of tasks over care (Harrison & Zohhadi, 2005). This then reinforces the notion that the task is more important than care.

The clinical governance structure of organisations does not necessarily provide the assurance of a quality and safe health service. Where the policies and procedures are tangible practices to follow, the impact of individual emotional experiences, such as suicide anxiety impact on nursing proficiencies.

The senior nurses, whilst acknowledging that care for this cohort of patients could be better, also recognise the difficulty in maintaining a professional role when they encounter a patient who requires more than they are able to provide. This leads to not delivering person centred practice in which nursing becomes task focused and minimalistic, where the patients are viewed as a burden and something to be managed rather than to whom care is provided.

Organisations need to ensure that nurses are provided with the appropriate resources in order to perform their roles as required. This includes education about suicide and attempted suicide, but interwoven with how to respond to this cohort of patients from a person-centred perspective.

Nurses can only help others if they are in a position to help (Meadors & Lamson, 2008; Santa Mina et al, 2009), and whilst they may be in a profession that places them in positions to help others, nurses need to have the clinical support, personal strengths, resilience and opportunity for reflection on their own practice and personal beliefs, in order to provide the nursing care required for such difficult situations. It is important that nurses gain an understanding of the impact of suicide anxiety as it has a direct correlation to the care and wellbeing of a person who has attempted suicide as well as to their own resilience and wellbeing.

This chapter has presented the qualitative components of the study and the papers that have been submitted for publication. The themes identified within the papers (Figure 4.2) are suicide anxiety, not being person centred, risk, communication, emotions, failure to care, facing blame and needing to protect. These themes aide in the understanding of the attitudes and behaviours exhibited by nurses who provide suicide attempt aftercare.

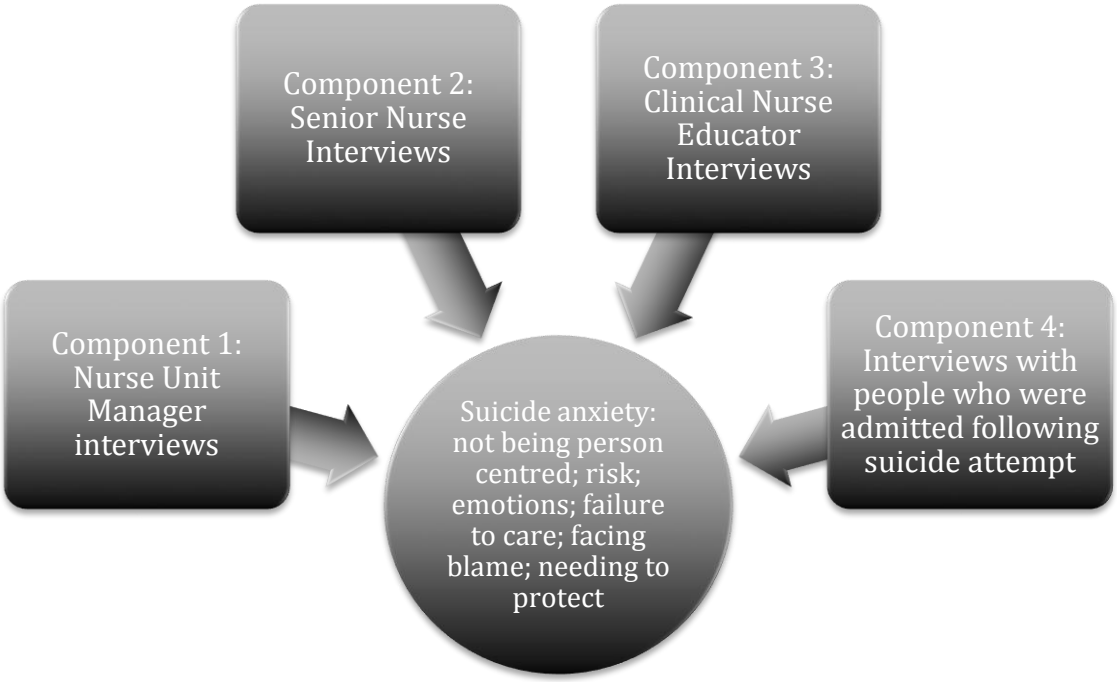

Figure 4.2: Themes arising from qualitative components

Chapter Five: Quantitative results

Chapter five presents the results of the quantitative component of the research, with one paper in press and another paper submitted for publication forming the base on which the discussion is centred. Table 9 provides a summary of the quantitative papers presented within this chapter. A brief discussion follows the presentation of the papers.

Table 5.1: Papers presented within this chapter

Research Process Components	Quantitative Approach Component Five	Quantitative Approach Component Six
Design	Cross-sectional Survey	Cross-sectional Survey
Participants	Purposive sample of nurses (n=72)	Purposive sample of nurses (n=72)
Data Collection	Questionnaire: Demographic, ETOS & ATAS-Q	Questionnaire: Demographic, DSQ-88
Analysis	Descriptive and inferential Statistics	Descriptive and inferential Statistics
Findings	Themes identified: shame and blame; misunderstandings and myths	Themes identified: blame and rationalizing transgression

Paper Three: Therapeutic optimism and attitudes among medical and surgical nurses towards attempted suicide

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ORIGINAL ARTICLE

Therapeutic optimism and attitudes among medical and surgical nurses towards attempted suicide

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ABSTRACT: *Identification of the attitudes to consumers admitted to hospital following a suicide attempt and the therapeutic optimism of nurses caring for this cohort is vital to ascertain the level of nursing care provided. A convenience sample of 72 Registered and enrolled nurses from a large metropolitan health service in South Eastern Melbourne, Australia, completed a demographic questionnaire, the Elsom Therapeutic Optimism Scale (ETOS), and the Attitudes to Attempted Suicide-Questionnaire (ATAS-Q). Data were analysed using SPSS (version 25). Whilst the ETOS & ATAS-Q correlate positively, themes of shame, blame, misunderstandings, and myths about suicide influence nurses' perspectives when providing suicide attempt aftercare. This may potentially lead to care that is tokenistic and task focused. To develop their professional skill set when providing suicide attempt aftercare, nurses need both formal and informal education and opportunities to reflect on their practice.*

KEY WORDS: *attitude, therapeutic optimism, nurses, attempted suicide.*

INTRODUCTION

It is estimated that internationally, over 800,000 people die by suicide (World Health Organization, 2014), with data showing that in 2016, in Australia, there were 2866 reported deaths by suicide (Australian Bureau of Statistics, 2017). The numbers of people dying by suicide each year in Australia have been increasing since 2007 (Australian Bureau of Statistics, 2017). Reports indicate that many more people attempt suicide each year (World Health Organization, 2014; Australian Bureau of Statistics, 2008). This means that people may be admitted to general hospitals following a suicide attempt for treatment and stabilization of their physical health. Subsequently, Registered and enrolled nurses may care for a person who has attempted suicide even if they do not work in the mental health setting (Lakeman 2010). It is therefore important to ascertain the knowledge and skills of nurses who provide suicide attempt aftercare, as well as their attitudes and therapeutic optimism towards these people.

BACKGROUND

It has long been recognized that providing suicide attempt aftercare affects nurses in different ways. It may cause anger, frustration, withdrawal of care, hostility, fear, helplessness, lack of empathy, perceptions of lack of competence, and feelings of being manipulated (Alston & Robinson 1992; Doyle *et al.* 2007; Gibb *et al.* 2010; Johnstone 1997; McAllister *et al.* 2002; McLaughlin 1995; Valente & Saunders 2004; Vivekananda 2000). There are three factors that influence the formation of attitudes: mental reasoning (conscious or unconscious), emotional context and content, and action outcomes (Altmann 2008). A critical interpretive analysis conducted by Talseth and Gilje (2011) summarized findings from a number of studies related to the attitudes of both mental health and nonmental health

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nurses. They found that positive attitudes may be attributed to older nurses, those who have additional qualifications, and who ascribe to religious beliefs and nurses who have provided suicide attempt aftercare for more than ten people (Talseth & Gilje, 2011). In addition, both mental health community nurses and nurses from emergency departments were shown to have more positive attitudes (Talseth & Gilje, 2011). Suicide and attempted suicide are often considered taboo and shrouded in stigma with the formation of attitudes towards suicide based on these factors (World Health Organization, 2014). Positive attitudes of clinicians towards people who have attempted suicide have constructive outcomes for these consumers, whereas negative attitudes lead to withdrawal and disengagement from consumers (Lau *et al.* 2015).

Therapeutic optimism refers to clinicians' experiences of positivity that may affect patient healthcare outcomes (Byrne *et al.* 2006). Evidence suggests that therapeutic optimism impacts positively for people when their clinicians believe that the work they undertake has a meaningful influence on the outcomes of the people for whom they provide care. Nurses who undertake further studies in order to enhance their ability to provide nursing care are more likely to have higher levels of therapeutic optimism (Rogers *et al.* 2013). Interestingly, a nurse may exhibit broadly negative attitudes and still continue to provide therapeutically positive care for people following a suicide attempt (Rogers *et al.* 2013).

PARTICIPANTS AND SETTING

A convenience sample of Registered and enrolled nurses (n = 72) working within six medical and surgical units at three hospital campuses of a major metropolitan health service in South East Melbourne, Australia, was recruited into this study. All participants were aged over 18 and capable of providing consent. Nurses who were not working during the data collection period, for example on maternity leave, annual leave, long service leave, or long-term sick leave, were excluded from participating. The data collection period was from February 2015 to November 2016.

PROCEDURES

Aim

The aim of this study was to investigate the relationship between therapeutic optimism and attitudes towards attempted suicide of nurses who work in medical/surgical specialties. This study is one part of a wider study that investigated nurses' facility for the provision of nursing care to consumers postsuicide attempt. It addressed their respective attitudes and optimism and the defence mechanisms they employ when working with this cohort. The overall study had one key aim: to explore the factors that influence the attitudes and behaviours of nurses working in acute care settings and their skills and knowledge in relation to working with people following a suicide attempt. The results reported in this manuscript are applicable to the factors influencing behaviour and not the skills and knowledge of nurses.

Recruitment of participants

One research team member presented the study to nurses during their clinical handover period and during their scheduled in-service education timeslot. In order to assist with the recruitment of participants, ward champions were identified. These were the Unit Managers and Mental Health Consultation Liaison Nurses. In order to avoid perceptions of coercion, champions routinely reminded nurses of the study.

Ethical considerations

Ethics approval for this study was obtained from the Health Service Human Research Ethics Committee (approval number 12373B). Consent for the cross-sectional survey questionnaire was implied by completion of the survey.

Data collection

Electronic and paper-based copies of the surveys were provided to the champions to enable nurses to complete and for follow-up reminders. Completed paper-based surveys were returned to a sealed box in the staffroom. Due to the strong psychometric properties of the ETOS and ATAS-Q instruments, it was not necessary to conduct a pilot study with this population. Data were gathered related to participant demographics, therapeutic optimism, and attitudes to attempted suicide of nurses working in general (non-mental health) hospital environments. Demographic data included age and gender, qualifications, where qualifications were attained as well as any specialist education received.

Instruments

Elsom Therapeutic Optimism Scale (ETOS)

ETOS is typically used in mental health settings, measuring the level of optimism experienced by clinicians relative to the effect of their interactions with consumers (Happell *et al.* 2012). Whilst normally used in these settings, the ETOS has also been used with midwives (Lau *et al.* 2015) to measure the influences of an advanced perinatal mental health education programme and with nurse practitioner students as a pre- and post-test measure of therapeutic optimism following an educational intervention (Rogers *et al.* 2013). The ETOS is a 10-item scale, using a 7-point Likert-type format, anchored between strongly disagree (1) and strongly agree (7). Positive optimism correlates to higher scores (highest possible score is 70). ETOS is reported to have strong internal consistency, with Cronbach's alpha reports range from 0.81 to 0.89 (Elsom & McCauley-Elsom 2008; Happell *et al.* 2012). Four items are negatively worded and were scored in reverse ensuring consistency of scoring. Reverse scoring ensures that participants carefully consider each question and then provide thoughtful responses, also minimizing risk of response bias.

Attitudes To Attempted Suicide-Questionnaire (ATAS-Q)

ATAS-Q is used to measure attitudes towards attempted suicide. ATAS-Q has 80 items assessing eight factors: positiveness, acceptability, religiosity, professional role and care, manipulation, personality traits, mental illness, and discrimination. The questionnaire uses a 5-point Likert-type format, anchored between strongly disagree and strongly agree. Negative attitudes correlate to low scores (lowest score is 80), whilst more positive attitudes correlate to high scores (highest score possible is 400). ATAS-Q is reported to have high construct and face validity (Ouzouni & Nakakis 2009, 2012, 2013). Two independent researchers determined ATAS-Q Cronbach's alpha at 0.97, reflecting high internal consistency (Ouzouni & Nakakis 2012, 2013).

Statistical analysis

Data were entered into IBM SPSS version 25 (IBM Corp 2017), after cleaning and coding. Missing data were treated based on the nature of the variable. Means were substituted for continuous variables. Missing data from noncontinuous variables were omitted from the analysis. Descriptive analyses were conducted on all variables. The ETOS and ATAS-Q individual and total score items were analysed using independent t-test and analysis of variance (ANOVA) and correlated between groups using Pearson product moment correlation and Spearman rank-order correlation. $p \leq 0.05$ was considered to be statistically significant.

RESULTS

A total of 72 participants completed the survey ($n = 72$) from a potential total of 216. Only 11 surveys were completed electronically. Demographic data provide information regarding the nurses who participated in the study. Whilst the majority of nurses obtained their initial nursing qualification in Australia, primary qualifications were also obtained from China, Fiji, India, Philippines, New Zealand, Scotland, and Zimbabwe. Interestingly, 56% of nurses did not obtain their qualification through enrolment at a tertiary education provider. Two nurses held dual registration as both a registered nurse and an enrolled nurse, with one obtaining additional qualifications, and another held dual registration as a registered nurse and registered midwife. Of the additional qualifications obtained, 34 participants reported they held additional credentials, with some holding more than one. Overall, the additional qualifications equated to 40 recognized educational certifications, of which 17 related to nursing (IV cannulation, chemotherapy administration, midwifery, mental health, medical/surgical, and medication endorsement). Other qualifications included business management, aged care, childcare, primary teaching, emergency health (paramedic), arts, massage therapy, public health, training and assessment, community welfare, medicine and homeopathic medicine, and surgery. Table 1 provides an outline of the participants' demographics.

With regard to the question related to whether participants considered themselves prepared to care for people following a suicide attempt, overwhelmingly, participants have not received education that may support them in their role generally and more specifically when caring for people admitted for suicide attempt aftercare. Table 2 represents the education elements received by nurses in this study within their workplace.

The participants' ETOS results reflect slightly lower than moderate levels of therapeutic optimism (M = 41.35, SD = 6.38). For participants in the age group 30–50 years ($M = 43.75$, SD = 6.80), results indicate that they were the group with higher levels of therapeutic optimism; however, these indicate only slightly higher than moderate scores. ETOS results

TABLE 1: *Demographics*

	n = 72	(%)
Gender		
Female	66	91.7
Male	5	6.9
Intersex	1	1.4
Age group (year)		
18-29	25	34.7
30–50	29	40.3
51+	18	25
Registered nurses[†]	57	79.1
Enrolled nurses	15	20.9
Initial qualification obtained		
Australia	64	88.9
Overseas	8	10.1
Hours of work		
Part time[‡]	36	50
Full time	35	48.6
Casual	1	1.4
Experience in mental health		
Yes	23	31.9
No	49	68.1
Could be better prepared to work with suicide attempters		
Yes	62	86.1
No	10	13.9

[†]34 (47.2%) have additional qualifications.
[‡]16 (22.2%) work 32 hours per week.

TABLE 2: *Education elements received*

	n = 72	(%)
Grief and loss counselling		
Yes	17	23.6
No	55	76.4
Interviewing skills		
Yes	12	16.7
No	60	83.3
Critical incident debriefing		
Yes	9	12.5
No	63	87.5
General counselling skills		
Yes	13	18.1
No	59	81.9
Individual therapy		
Yes	1	1.4
No	72	98.6
Group work		
Yes	7	9.7
No	65	90.3
Alcohol use/abuse		
Yes	16	22.2
No	56	77.8
Illicit drug use/abuse		
Yes	16	22.2
No	56	77.8
Psychopharmacology		
Yes	6	8.3
No	66	91.7
Mental status examination		
Yes	20	27.8
No	52	72.2
Suicide risk assessment		
Yes	13	18.1
No	58	80.6

indicate no difference between genders recognizing the low numbers of male and intersex participants. Interitem correlation between the elements demonstrates significant consistency.

The participants' ATAS-Q responses indicated that they had moderately poor attitudes towards suicide and attempted suicide (M = 209.44, SD = 25.46), with the lowest score being 160, and the highest being 263. ATAS-Q results indicate moderately low-to-moderate scores among the different factors (Table 3). The ATAS-Q results indicate that the age group 30–50 years had more positive attitudes towards suicide (M = 216.07, SD = 26.19).

Themes may be interpreted from the application of Spearman's correlations within the eight factors of the ATAS-Q. For Positiveness, nurses indicate that they are happy to provide suicide attempt aftercare ($r_s = -0.239$, $P = 0.44$). However, items relating to shame and blame (*People who attempt suicide are irresponsible:* $r_s = 0.300$, $P = 0.10$) and misunderstandings and myths (*Those who attempt suicide are cowards who cannot face life challenges*: $r_s = 0.570$, $P = 0.000$) may negate some of the positiveness. Within the factor for Acceptability, nurses indicate some degree of permissiveness in that they identify scenarios when suicide may be a rational decision (*Suicide is an acceptable means to end an incurable illness:* $r_s = .824$, $P = 0.000$). There were significantly positive correlations for every item on the Religiosity factor (*Suicide goes against the laws of God:* $r_s = 0.674$, $P = 0.000$).

TABLE 3: *ATAS-Q descriptive statistics*

	Mean	Std. deviation
Positiveness	71.18	8.78
Acceptability	29.99	6.31
Religiosity	14.87	6.65
Professional role and care	30.64	3.43
Manipulation	13.08	4.63
Personality traits	11.17	3.33
Mental illness	24.79	4.66
Discrimination	13.61	2.90
Total ATAS-Q	209.44	25.46

Participants believed that they are providing good care to people following a suicide attempt (*Patients in the place/unit I work receive good care:* $r_s = 0.305$, $P = 0.009$). However, with regard to the Professional Role and Care domain, there are indications that there is a lack of insight (*Attempted suicide patients receive a good therapeutic care in the unit where I work*: $r_s = 0.316$, $P = 0.007$) as to what constitutes best practice in suicide attempt aftercare. This is despite their acknowledgement that they had not received education (*I believe that the training I have completed to date, has given me adequate skills to care for patient who have attempted to commit suicide*: $r_s = 0.331$, $P = 0.005$). For Manipulation, the results are strongly correlated with themes of shame and blame (*Attempted suicide patients mainly try to manipulate their situation to their advantage*: $r_s = 0.679$, $P = 0.000$). Personality traits indicate strong signs for misunderstandings and myths (*Most people who attempt suicide do not really want to die*: $r_s = 0.258$, $P = 0.029$). Within the Mental Illness domain, there are indications that nurses believe that people in receipt of suicide attempt aftercare should be treated within specialist mental health facilities and not within their ward environments ($r_s = 0.471$, $P = 0.000$). This is supported in the factor for Discrimination, where the results indicate that people should receive suicide attempt aftercare from mental health professionals ($r_s = 0.357$, $p = 0.002$).

A one-way between-groups analysis of variance (ANOVA) was conducted to explore the impact of age on levels of therapeutic optimism and attitudes towards attempted suicide. Post hoc comparisons using the Tukey HSD test indicated that the mean score for Group 2 was significantly different from Group 3; however, Groups 1 and 3 did not differ significantly, nor did Groups 1 and 2. ETOS – F (2, 69) = 5.2, $P = 0.008$. The Tukey HSD test did not indicate significant difference between groups for the ATAS-Q. Tukey HSD analysis demonstrated that the age group that is both more therapeutically optimistic and hold more positive attitudes towards suicide is the 30- to 50-year-old cohort. Nevertheless, they score only slightly above moderate for both instruments. Tables 4 and 5 provide the compared means and the ANOVA between ETOS, ATAS-Q, and age.

TABLE 4: *Compared means for age, ETOS, and ATAS-Q*

Age		Mean	Std. deviation
18–29	ETOS total	41.15	5.99
Group 1	ATAS-Q total	202.85	23.47
30–50	ETOS total	43.75	6.80
Group 2	ATAS-Q total	216.07	26.19
51+	ETOS total	37.89	4.63
Group 3	ATAS-Q total	208.67	25.89

TABLE 5: *ANOVA for age, ETOS, and ATAS-Q*

	ANOVA				
	Sum of Squares	df	Mean square	*F*	Sig.
ETOS total					
Between groups	377.907	2	188.954	5.198	.008
Within groups	2508.412	69	36.354		
Total	2886.319	71			
Total ATAS-Q					
Between groups	2372.536	2	1186.268	1.875	.161
Within groups	43 649.242	69	632.598		
Total	46 021.778	71			

DISCUSSION

This study aimed to ascertain the therapeutic optimism and attitudes towards attempted suicide of medical/surgical nurses who provide suicide attempt aftercare. Two major themes were identified as follows: (i) shaming and blaming and (ii) misunderstanding and myths. We argue that these themes are derived from broader societal perspectives about attempted suicide rather than professional perspectives within nursing. Saigle (2016) reports that the attitudes of nurses affect their ability to provide nursing care to people subsequent to a suicide attempt. Of note, is the concept of malignant alienation when considering how therapeutic relationships can break down as a result of four key factors: patients, staff, staff–patient interaction, and hospital environment (Watts & Morgan 1994). Malignant alienation is a term characterized by a gradual decline in the therapeutic relationship between nurses and patients and exhibits as a waning of sympathy and support from staff (Watts & Morgan 1994). An extension to the concept of malignant alienation is that of therapeutic nihilism, which occurs when suicide is viewed as an inevitable outcome and results in the loss of hope of both clinicians and patients (Sadock *et al.* 2017). It is the antithesis of therapeutic optimism, yet given the low scoring of the ETOS may further explain the results.

Shame and blame are consistently observed in the literature regarding attitudes towards suicide (Talseth & Gilje 2011; Vatne & Nåden 2014) and are perspectives found within the general public, healthcare providers, and consumers themselves. The constructs of

blame and shame are similar between groups, but their essence and impact are disparate (Corrigan *et al.* 2017). Shame and blame are often used interchangeably and following a suicide attempt are emotions that are frequently experienced (Berg *et al.* 2017; World Health Organization, 2014). They are attributed to a number of factors, some of which inform societal impressions of the person who are suicidal. These impressions are that the person is weak, selfish, attention seeking, a failure, or unworthy (Carpiniello & Pinna 2017; Vatne & Nåden 2014). The results of our study indicate that nurses' beliefs in religion and subsequently people's observance of religion or religious beliefs are representative of individual coping strategies. Another study demonstrated that prejudicial attitudes towards people who attempt suicide exist, with participants indicating that these actions are 'punitive, selfish, offensive, or reckless' (Carpiniello & Pinna 2017). Shame and blame lead to stigma, which by its nature is discriminatory. The results of this study have indicated that permissiveness does not relate to the other seven factors and could be indicative of discriminatory beliefs.

To avoid exposure to these experiences, avoidance of help seeking occurs, further exacerbating the underlying issue (Arendt *et al.* 2017; Carpiniello & Pinna 2017; Vatne & Nåden 2014). The notion of internal stigma builds on the feelings of shame because it enhances what the individual experiences, and also assumes negative perspectives leading to discriminatory behaviour from others (Scocco *et al.* 2016). It refers to the negative emotions of shame and anticipated prejudice of individuals that prevents them from engaging in help seeking and to the avoidance of others (Scocco *et al.* 2016). Both shame and internal stigma contribute to the exacerbation of the risk of attempting suicide (Carpiniello & Pinna 2017; Oexle *et al.* 2017; Scocco *et al.* 2016).

Misunderstanding and myths about suicide and suicidal behaviour arise from misinformation or ignorance related to widely held and shared misconceptions and are considered to contribute to an already significant health issue (Arendt *et al.* 2017). These myths often founded in distortion and half-truths occur because of the stigma associated with suicide and suicidal behaviour (Niederkrotenthaler *et al.* 2014). It is well recognized that the most effective tool to combat myths is accurate and truthful information (Arendt *et al.* 2017; Niederkrotenthaler *et al.* 2014). However, nurses in this study report that they have not received education pertaining to mental health care and specifically to suicide and attempted suicide. Consequently, they continue to exhibit antipathy towards people who are suicidal (Rebair & Hulatt 2017). In 2010, the Australian Federal, Senate Community Affairs Committee Secretariat (2010) recommended that education in suicide awareness and prevention be adopted by all health professionals in their undergraduate training and maintained throughout their careers. A small study conducted in one university in the UK (Rogers *et al.* 2013) showed that therapeutic optimism increased as a result of a targeted education programme. However, the authors acknowledged that this group of students had pre-existing high levels of therapeutic optimism, which may be attributed to their commitment to furthering their careers.

LIMITATIONS

The current study has some limitations. It was carried out in one health service, potentially limiting generalization to other organizations, particularly as there is a low response rate of completion among the participants. As the nurses' self-selected to participate in the study, selection bias could be increased. Nurses who did not participate may hold different attitudes towards attempted suicide. The participant response rate has been unable to be calculated because the number of staff absent has meant that assumptions about total number of potential participants cannot be inferred.

CONCLUSION

This study demonstrates that nurses' attitudes towards people who have attempted suicide are related to levels of therapeutic optimism, but are, couched in shame and blame as well as misunderstanding and myths. With higher the levels of therapeutic optimism, more positive attitudes are expressed.

RELEVANCE FOR CLINICAL PRACTICE

Exploring the relationship between therapeutic optimism and attitudes towards suicide would benefit from further research. Ascertaining the therapeutic optimism and attitudes towards attempted suicide of medical and surgical nurses is important as both of these dynamics influence the ability of nurses to provide suicide attempt aftercare that is compassionate and beneficial. It would be interesting to conduct observational studies of these nurses to ascertain how therapeutic optimism and attitudes towards suicide translates into nursing care.

Awareness of therapeutic optimism and attitudes towards attempted suicide of medical and surgical nurses provides healthcare organizations with the opportunity to deliver specific educational elements that transform the way in which nurses provide suicide attempt aftercare. Organizational commitment to the lifelong learning of their employees through the use of formal and informal education must translate into the employment of education staff and future development. Opportunities for reflection on practice through the mechanisms of clinical supervision or action learning are essential when attempting to redress practice issues. This is pertinent in organizations where low therapeutic optimism translates as therapeutic nihilism or malignant alienation. In order for care to be delivered that is compassionate and person-centred, organizations need to revisit recruitment and retention strategies. Consideration of organizational culture should be undertaken through the use of workplace health and pulse checks, with values and code of conduct practices clearly articulated to all employees.

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Paper Four:

An investigation of the defense styles of medical and surgical nurses when providing suicide attempt aftercare.

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Abstract:

Providing suicide attempt aftercare is considered to strain the capabilities of medical and surgical nurses. The ways in which they subconsciously redress this strain is by the adoption of defense mechanisms. A convenience sample of 72 nurses completed a demographic questionnaire and the Defense Style Questionnaire – 88 (DSQ-88). All nurses hailed from a large metropolitan hospital in South East Melbourne, Australia. The data was analysed operating SPSS (version 25). Two themes arose from the participants' responses: blame and rationalising transgression**.** Nurses adopt defenses to counteract the anxiety inducing aspects of their role. Nursing is an inherently anxiety provoking profession, with the provision of suicide attempt aftercare one of the most significant stressors experienced by nurses. Defense use is not limited solely to the work environment.

Key words; anxiety, defense mechanisms, attempted suicide, nurses

Background:

Nurses work in environments that may be considered to intensify experiences of anxiety in that they are exposed to illness, death, fear, burden and distress on a frequent basis (Regan et al, 2009; Gray, 2009; Stein-Parbury, 2014). These experiences may also be heightened when people are admitted into their care subsequent to a suicide attempt in order for them to obtain physical health treatment. The Australian Bureau of Statistics reports that in Australia, in 2016, 2866 people suicided (ABS, 2017) and given that many more people attempt suicide (WHO, 2014), the assumption exists that nurses will at some point in their career provide care for someone who has attempted suicide (Lakeman, 2010). However, inexperience, combined with knowledge and skill deficits in providing suicide attempt aftercare can be anxiety provoking and may lead to avoidance of consumers and barriers to person-centred care (Saigle, 2016).

It is well recognised that nurses are prone to experience anxiety in the workplace (Regan et al, 2009; Stein-Parbury, 2014), with the authors of this paper purporting that the ability to provide suicide attempt aftercare can be effected by a perception referred to as suicide anxiety. Suicide anxiety occurs through the combination of two constructs: risk and interpersonal interaction. Risk being comprised of three sub constructs: environment, resources and capability/efficacy. Similarly, interpersonal interaction is also comprised of three sub constructs: avoidance, macabre interest and stigma.

Defence mechanisms are generally unconscious mental processes aimed at protecting the individual from anxiety-induced internal conflict or dissonance that can be perpetuated by both internal and external stimuli (Cramer, 2006). Of relevance are the defense mechanisms that are in play when nurses provide suicide attempt aftercare.

Participants and setting:

A major metropolitan hospital in South East Melbourne, Australia that comprised three acute hospital campuses was the site selected for this study. Within each hospital, 1 medical and 1 surgical unit, a convenience sample of Registered and Enrolled Nurses (N=72) was recruited into this study. Each nurse was aged over 18 and capable of providing consent. Nurses who were absent from work during the data collection period were excluded from participating. The data collection period was between February 2015 and November 2016.

Procedure:

The study was presented to the nurses during their clinical handover or during their scheduled in-service education by one of the researchers. Each ward had a champion to prompt completion and facilitate opportunities for the nurses to complete the instruments. The Unit Mangers self-selected to take on that role, supported by Mental Health Consultation Liaison Nurse from two hospitals. Both electronic and paper-based copies of the surveys were provided. It was not necessary to conduct a pilot study due to the strong psychometric properties of the DSQ-88 instrument. Both the Health Service and University Human Research Ethics Committees Ethics provided approval for this study. Consent from participants for the cross-sectional survey questionnaire was implied by completion of the survey.

This study is a part of a broader mixed methods study forming part of a PhD of one of the authors. The qualitative components of the study explored the expectations of senior nurses and experiences of patients related to nursing care provision following a suicide attempt. The quantitative components of the study investigated attitudes towards attempted suicide, therapeutic optimism and defense mechanisms of nurses who provide

suicide attempt aftercare in general (non-mental health) hospital environments. Demographic data obtained included age, gender, qualifications and where they were attained and any further education pertinent to the study. The overall research had one key aim: exploration of dynamics that effect the behaviours of Nurses working in acute care settings and their proficiencies relative to working with people requiring suicide attempt aftercare. The results reported in this paper are pertinent to the factors influencing behaviour, not that of skills and knowledge.

Statistical analysis

Data were entered in to SPSS (Version 25) (IBM, 2017) after cleaning and coding. Missing data were treated based on the nature of the variable. Means were substituted for continuous variables. Missing data from non-continuous variables were omitted from the analysis. Descriptive analyses were conducted on all variables. The DSQ-88 individual and total score items were analysed using independent *t*-test and analysis of variance (ANOVA) and correlated between groups using Pearson product moment correlation and Spearman rank-order correlation. p 0.05 was considered to be statistically significant.

The Defense Style Questionnaire (DSQ-88)

The Defense Style Questionnaire (DSQ-88) is comprised of 88 items that measures 20 defenses and four defense styles (Cramer, 2006). Of the 88 items, 10 are considered to be ❸ie❾(Cramer, 2006, p324) statements as they represent societal perspectives (Bond & Wesley, 1996) rather than defenses (Cramer, 2006). The four defense styles are: *maladaptive action, self-sacrificing, image-distortion and adaptive* (Ramkissoon, 2014). The questionnaire is a 9-point likert scale that reflects the participant♦❼greement or disagreement with a statement. High scorings on any one variable indicates the usage of

that defense (Bond & Wesley, 1996). The DSQ-88 is reported to have adequate test-retest reliability (Ramkissoon, 2014), with internal positive correlations (Bond & Wesley, 1996). Cronbach alpha coefficients; *p*=0.001; Maladaptive 0.73, Self Sacrificing 0.71, Image Distortion 0.68, Adaptive 0.69 (Bond et al, 1989). The DSQ-88 has been used with people in clinical settings and in non-clinical settings including high-school students and employee cohorts (Cramer, 2006; Ramkissoon, 2014).

Results

Demographic data were collected for the purpose of identifying information pertinent to the individual experiences of participants. A total number of 72 participants (*n* = 72), comprising a combination of Registered and Enrolled Nurses self selected to complete the survey. Table 1 provides a summary of the participants' demographics. The majority of nurses obtained their initial nursing qualification in Australia (n = 64), however nursing qualifications were also obtained from China, Fiji, India, Philippines, New Zealand, Scotland and Zimbabwe. Of note, less than 44% of participants gained their nursing qualification at a tertiary institution. Three participants held dual registrations, one of which was a Registered Nurse and Midwife, whilst the other two were both Registered Nurse and Enrolled Nurses. Overall, 40 additional qualifications were attained by 34 participants, with some individuals credentialed with more than one, only 17 of which related to nursing (IV cannulation, chemotherapy administration, midwifery, mental health, medical/surgical and medication endorsement). The other qualifications realized by the participants included a variety of educational/ vocational qualifications including teaching, social work and medicine.

Table 1: Summary of participant demographics

	n=72	(%)
Gender		
Female	66	91.7
Male	5	6.9
Intersex	1	1.4
Age group (year)		
18-29	25	34.7
30-50	29	40.3
51+	18	25
Registered Nurses*	57	79.1
Enrolled Nurses	15	20.9

* 34 (47.2%) have additional qualifications

Of the 36 participants who reported they work part-time, 16 (22.2%) indicated that they work 32 hours per week. Only 23 participants (31.9%) indicated that they had experience in mental health, however the majority of these responses relate to clinical placement opportunities during their initial nursing qualification. When asked whether they could be better prepared to care for people post suicide attempt, the majority (n=62, 86.1%) responded in the affirmative. Information was obtained as to the types of education the participants had received (Table 2) that may assist them when providing suicide attempt aftercare.

Mental status examination (MSE)	n = 20, 27.8%
Grief and loss counselling	*n* = 17, 23.6%
Alcohol use/ abuse	*n* = 16, 22.2%
Illicit drug use/ abuse	*n* = 16, 22.2%
General counselling skills	*n* = 13, 18.1%
Suicide risk assessment	*n* = 13, 18.1%
Interviewing skills	*n* = 12, 16.7%
Critical incident debriefing	*n* = 9, 12.5%

Group work	*n* =7, 9.7%
Psychopharmacology	*n* = 6, 8.3%
Individual therapy	*n* = 1, 1.4%

Table 2: Details of education received

Ranked highest to lowest, MSE is highest at 27.8%, 22% have drug and alcohol education (presumably with some form of motivational interviewing and 18-23% have some form of counselling skills. Overwhelmingly, knowledge and skills pertinent to this patient cohort are lacking.

The participants' DSQ-88 responses indicated that their use of defense styles varied amongst the types (Table 3), indicating low to moderately low use of defense styles when providing suicide attempt aftercare (*Maladaptive scores 41 to 165; Image Distortion scores 17 to 75; Self sacrificing scores 20 to 50; Adaptive scores 17 to 59)*.

Table 3: DSQ-88 Defense Styles descriptive statistics

	Mean	Std. Deviation
Maladaptive	107.03	0.779
Image distortion	45.74	28.32
Self sacrificing	34.71	12.19
Adaptive	38.21	8.22

Table 4: Compared means for age and DSQ-88 factors

		Mean	Std. Deviation
Maladaptive	18-29	108.27	31.47
	30-50	111.14	25.47
	51+	98.83	27.58
Image Distortion	18-29	44.38	10.98

	30-50	49.11	11.85
	51+	42.44	13.66
Self sacrificing	18-29	34.23	7.89
	30-50	36.07	8.26
	51+	34.71	4.07
Adaptive	18-29	37.31	7.68
	30-50	38.14	9.73
	51+	39.61	6.45

A one-way between-groups analysis of variance was conducted to explore the impact of age on defense styles adopted by nurses providing suicide attempt aftercare. Post hoc comparisons using the Tukey HSD test did not indicate significant difference between age groups. However, Tukey HSD analysis demonstrated that the age group that may be considered to be use Maladaptive styles is the 30-50 years old cohort. This group also demonstrated higher levels of Image Distortion and Self Sacrificing defences in use. The 51+ age group demonstrated higher levels of Adaptive defences. Overall, the 30-50 years old cohort display higher usage of defense styles than the other age groups (*M* = 234.46, *SD* = 39.52). Tables 4 and 5 provide the compared means and the ANOVA for DSQ-88 and age, whilst Table 6 provides ANOVA for Hospital of employment and DSQ-88. 2 participants work across all three hospitals.

		Sum of squares	Df	Mean Square	F	Sig.
Maladaptive	Between groups	1722.90	2	861.45	1.08	0.346
	Within groups	55203.04	69	800.04		
	Total	56925.94	71			
Image distortion	Between groups	560.71	2	280.36	1.94	0.152
	Within groups	9981.28	69	144.66		
	Total	10541.99	71			
Self sacrificing	Between groups	94.80	2	47.396	.888	0.416
	Within groups	3682.08	69	53.364		
	Total	3776.88	71			
Adaptive	Between groups	56.63	2	28.32	.412	0.664
	Within groups	4739.25	68	68.69		
	Total	4795.88	71			

Table 5: ANOVA for age and DSQ-88 factors

		Sum of Squares	df	Mean Square	F	Sig.
Maladaptive	Between Groups	3671.01	2	1835.50	2.347	0.103
	Within Groups	53173.30	68	781.96		
	Total	56844.31	70			
Image Distortion	Between Groups	53.624	2	26.812	0.176	0.839
	Within Groups	10381.53	68	152.67		
	Total	10435.16	70			
Self Sacrificing	Between Groups	182.43	2	91.21	1.847	0.165
	Within Groups	3357.32	68	49.37		
	Total	3539.75	70			
Adaptive	Between Groups	150.68	2	75.34	1.122	0.332
	Within Groups	4566.81	68	67.16		
	Total	4717.49	70			

Table 6: ANOVA for Hospital of work and DSQ-88 factors

The relationship between the defenses within the DSQ-88 items was investigated using Spearman's Rank Order correlation (Table 7). For the Maladaptive items, the significant correlation indicated that if the participants were in crisis, they would not seek help from another in a similar situation (r_s = -0.270, p = 0.022). Within the Image Distortion defense, participants indicated with significant correlation between the statements: *There's no such thing as "finding a little good in everyone"*. *If you're bad, you're all bad* (r_s = 0.235, p =0.047*).* Two Maladaptive items were significant within the Self Sacrificing defense *everyone's against me* (r_s *= 0.*233, p = .048) and *Doctors never really understand what is wrong with me* (r_s = 0.290, p *= 0.*013). This item was also significantly correlated within the Adaptive defense (r_s = 0.288, p = 0.014). At the p=0.01 level (2-tailed), correlation was significant within Self Sacrificing for the item *people tend to mistreat me* (r_s = 0. 302, p = 0.020). Within the Adaptive defense, of the 12 items that correlated significantly, the majority of these items (n = 9) correlated significantly with Maladaptive defenses *I'm very shy about sex* (r_s = 0. 242, p = 0.041); *people tend to mistreat me* (r_s = 0.273, p = 0.020); *I am often driven to act impulsively* (r_s = 0. 288, p = 0.014); *I work more things out in my daydreams than in my real life* (r_s = 0. 247, p = 0.036); *I get openly aggressive when I feel hurt* (r_s = 0.288, p = 0.014);

everyone is against me (r_s = 0.295, p = 0.012); *I fall apart under stress* (r_s = 0.263, p = 0.026); *when I'm depressed or anxious, eating makes me feel better* (r_s = 0.285, p = 0.015).

Table 7: Spearman's rho Correlation Coefficient

		Maladaptive	Image distortion	Self sacrificing	Adaptive
Maladaptive	Correlation Coefficient	1.000	.436*	.329*	.075
	Sig. (2-tailed)	.	.000	.005	.529
Image distortion	Correlation Coefficient	.436*	1.000	.461*	.150
	Sig. (2-tailed)	.000	.	.000	.208
Self sacrificing	Correlation Coefficient	.329*	.461*	1.000	.371*
	Sig. (2-tailed)	.005	.000	.	.001
Adaptive	Correlation Coefficient	.075	.150	.371*	1.000
	Sig. (2-tailed)	.529	.208	.001	.

* Correlation is significant at p=0.01 (2-tailed)

Discussion

This study aimed to obtain knowledge of the defense mechanisms employed by medical and surgical nurses when providing care to people following a suicide attempt. The primary defense style employed by the participants is that of the adaptive defenses. There are two themes identified within the responses of the participants: blame and rationalising transgression.

Behaviours may occur in response to unconscious processes associated with managing anxiety (Scott et al, 1995; Parasuraman & Hansen, 1987; Cramer, 2006; Stein-Parbury, 2014), protecting self-esteem (Schimel et al, 2003; Aiyegbusi & Norton, 2009), self-image (Klein & Epley, 2016) and feelings of clinicians, such as fear of suicide occurring (Pope & Tabachnick, 1986). Of note, is the claim that defences are responsive to both internal and external changes because of their dynamic status (Regan et al, 2009). When nurses do not adequately provide suicide attempt aftercare, it is not necessarily a conscious decision to not provide care and may be exhibited as distancing or avoidance (both physically and emotionally), black humour and cynicism, degrading and belittling of consumers they are to

provide care for through blaming and shaming (Scott et al, 1995; Bakker & Heuven, 2006). Blame is a theme that is often expressed in the literature regarding suicide and suicide attempts (Scocco et al, 2016; Carpiniello & Pinna, 2017). It is regularly paired with shame attributes (WHO, 2014; Berg et al, 2017). Blame however, is attributed to ascribed negative connotations usually of entire groups and leads to labelling and collectivism as the person is viewed as being weak or unworthy (Vatne & Nåden, 2014; Carpiniello & Pinna, 2017). It also contributes to the inability of nurses to deliver care that is holistic and individualistic as evidenced by the statement that the nurses associated with *there's no such thing as "finding a little good in everyone. If you're bad, you're all bad.*

Rationalising transgression is a type of justification in use by the participants and is used to abate feelings of anxiety (Stein-Parbury, 2014). It is evident in a number of the responses of the participants to statements that were considered to be significant *I am often driven to act impulsively; I get openly aggressive when I feel hurt; when I'm depressed or anxious, eating makes me feel better.* Rationalisation is a way for people to feel entitled to the way they do, and is not seen as a reflection of failure on their part, also ascribes to the theory of cognitive dissonance (Flenady, et al., 2016; Festinger & Carlsmith, 1959). Rationalisation occurs in response to *forced compliance,* which given the accountability of nurses for their professional practice, exists when nurses are required to undertake tasks or care for patients to whom they are conflicted (Flenady, et al., 2016). Responding with rationalisation to *forced compliance* is a way of nurses to explain that they are not to blame for their thoughts and emotions, but are instead influenced to behave this way (Flenady, et al., 2016). By rationalising transgression, nurses are able to moderate the amount of anxiety experienced when they do not perform their role as intended (Flenady, et al., 2016).

Describing the nurse- doctor relationship as one that may be antagonistic and strained (Scott et al, 1995) is probably out-dated. Nevertheless, participants indicated across two defences: Self Sacrificing and Adaptive that *Doctors never really understand what is wrong with me.* Inferences could be made that this relates to matters of clinical practice and conflict within the workplace and may be indicative of poor communication, rather than that of a health issue. Assumptions are often made as to what drives people's behaviours. If nurses are displaying attitudes and behaviours that are not in confluence with doctors, with rationales postulated to explain them, the nurses might rightly perceive that doctors do not understand what is wrong with them. It has been proposed that maladaptive defense mechanisms that occur in response to fear and anxiety experienced by nurses, perpetuates these feelings as they are unable to dissipate because the originating stressor has not been confronted (Parasuraman & Hansen, 1987). Expounding this, we argue that maladaptive defenses contribute to negative patient experiences and outcomes, increased work burden and stress as well as decreased job satisfaction, which are consistent with the early work of Parasuraman and Hansen, (1987) and more recently, Jahn et al. (2016). However, employing mature defences and developing resilience and emotional intelligence are approaches that may be adopted by nurses to ensure that their coping mechanisms are adaptable to stressful events and patients.

Limitations:

The limitations of the current study include the potentially limiting generalisations to other organisations as it was conducted within one health service. Selection bias may have been increased due to the nature of nurses self-selecting to participate. Assumptions cannot be inferred as to the use of defence styles when providing suicide attempt aftercare, rather this

study is relevant for the overall defenses adopted by participants, however nurses were asked to respond to the survey as though they were reflecting on care provision to a suicidal person. The defense styles of the nurses who did not participate may vary from those within the study. Due to the combination approach of the survey administration, meaning assumptions about the total number of potential participants is unknown the authors have been unable to calculate the response rate. However, assumptions have been drawn from anticipated staffing numbers.

Conclusion

As stated earlier, healthcare environments are inherently anxiety-producing environments that influence the thoughts and emotions of all people who come in contact with them. Nurses, as employees of these organisations are exposed to anxiety on a frequent basis, more so when they are required to provide care to people outside of their recognised specialty and who also have indicated their wish to die. The ability to manage feelings of anxiety and subsequent blame and rationalising transgression is dependent upon nurses' resilience levels and employed coping strategies. Use of defense styles is one coping strategy that is adopted by nurses to titrate the levels of discomfort resulting from anxiety. They provide the means and opportunity for nurses to continue nursing and provide care to patients. Given that suicide anxiety exists within the premise of risk and interpersonal interaction, the ability to provide nursing care to people following a suicide attempt is significantly impinged when considering how defense mechanisms are deployed. A failure to redirect or resolve feelings of anxiety can lead to burnout, poor patient care and outcomes and job dissatisfaction.

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Chapter discussion

In order to triangulate the data produced from completion of ETOS, ATAS-Q and DSQ-88, Pearson Product Moment Correlations was conducted. Table 5.1 shows Pearson Product Moment Correlations for the three instruments, ETOS, ATAS-Q and DSQ-88. Of note are the items that are statistically significant at $p \leq 0.01$ across both correlational tests: *self-sacrificing* and *ATAS-Q ($p = 0.303$* and p = *0.310).* The *self- sacrificing item* of the DSQ-88 is also significantly significant at 0.05 with the ETOS *(p= 0.237).* Inferences may be drawn from this data, indicating that although the nurses outwardly exhibit positive behavior towards people who have attempted suicide, they do in fact, at least at an unconscious level have a very negative attitude towards this cohort. Nurses are often viewed as modest, humble and hardworking and recognized year on year as the most trusted profession (Girvin et al., 2016). These results bely that notion, that although it is true that nurses are hardworking, there is an underlying tension in that they are not as magnanimous or altruistic as perceived and that they behave outwardly so that they receive positive reinforcement and praise, subsequently feeding their ego.

Table 5.2: Pearson correlations for ETOS, ATAS-Q and DSQ-88

		ETOS total	Total ATAS-Q	Maladaptive	Image Distortion	Self-Sacrificing	Adaptive	Total DSQ-88
ETOS total	Pearson Correlation	1	0.212	0.101	0.182	.237*	-0.029	0.156
	Sig. (2-tailed)		0.074	0.396	0.126	0.045	0.812	0.190
	Sum of Squares and Cross-products	2886.32	2442.89	1300.31	1003.597	781.292	-106.208	2978.986
	Covariance	40.65	34.41	18.31	14.135	11.004	-1.496	41.958
Total ATAS-Q	Pearson Correlation	0.212	1	0.003	0.199	.303**	0.120	0.135
	Sig. (2-tailed)	0.074		0.980	0.094	0.010	0.316	0.257
	Sum of Squares and Cross-products	2442.89	46021.78	151.11	4378.44	3989.33	1781.33	10300.22
	Covariance	34.41	648.19	2.13	61.668	56.188	25.089	145.074
Maladaptive	Pearson Correlation	0.101	0.003	1	.511**	.339**	0.130	.904**
	Sig. (2-tailed)	0.396	0.980		0.000	0.004	0.276	0.000
	Sum of Squares and Cross-products	1300.31	151.11	56925.94	12509.53	4965.583	2149.583	76550.639
	Covariance	18.31	2.13	801.774	176.191	69.938	30.276	1078.178
Image Distortion	Pearson Correlation	0.182	0.199	.511**	1	.454**	0.124	.735**
	Sig. (2-tailed)	0.126	0.094	0.000		0.000	0.300	0.000
	Sum of Squares and Cross-products	1003.60	4378.44	12509.53	10541.97	2864.46	879.96	26795.93
	Covariance	14.14	61.67	176.19	148.48	40.344	12.39	377.41
Self- Sacrificing	Pearson Correlation	.237*	.303**	.339**	.454**	1	.376**	.605**
	Sig. (2-tailed)	0.045	0.010	0.004	0.000		0.001	0.000
	Sum of Squares and Cross-products	781.29	3989.33	4965.58	2864.46	3776.88	1599.38	13206.29
	Covariance	11.00	56.19	69.94	40.34	53.20	22.53	186.00
Adaptive	Pearson Correlation	-0.029	0.120	0.130	0.124	.376**	1	.383**
	Sig. (2-tailed)	0.812	0.316	0.276	0.300	0.001		0.001
	Sum of Squares and Cross-products	-106.21	1781.33	2149.58	879.96	1599.38	4795.88	9424.80
	Covariance	-1.496	25.90	30.28	12.39	22.53	67.55	132.74
Total DSQ-88	Pearson Correlation	0.156	0.135	.904**	.735**	.605**	.383**	1
	Sig. (2-tailed)	0.190	0.257	0.000	0.000	0.000	0.001	
	Sum of Squares and Cross-products	2978.99	10300.22	76550.64	26795.93	13206.29	9424.79	125977.65
	Covariance	41.96	145.07	1078.18	377.41	186.00	132.74	1774.33

*. Correlation is significant at the 0.05 level (2-tailed).

**. Correlation is significant at the 0.01 level (2-tailed).

This chapter has presented the two quantitative papers, one that is in press and another that has been submitted for publication. The themes arising from these papers are presented in Figure 5.1. The next chapter uses the Theory of Planned Behaviour to explain how the attitudes, therapeutic optimism and defense styles of nurses impact their behaviour when providing suicide attempt aftercare.

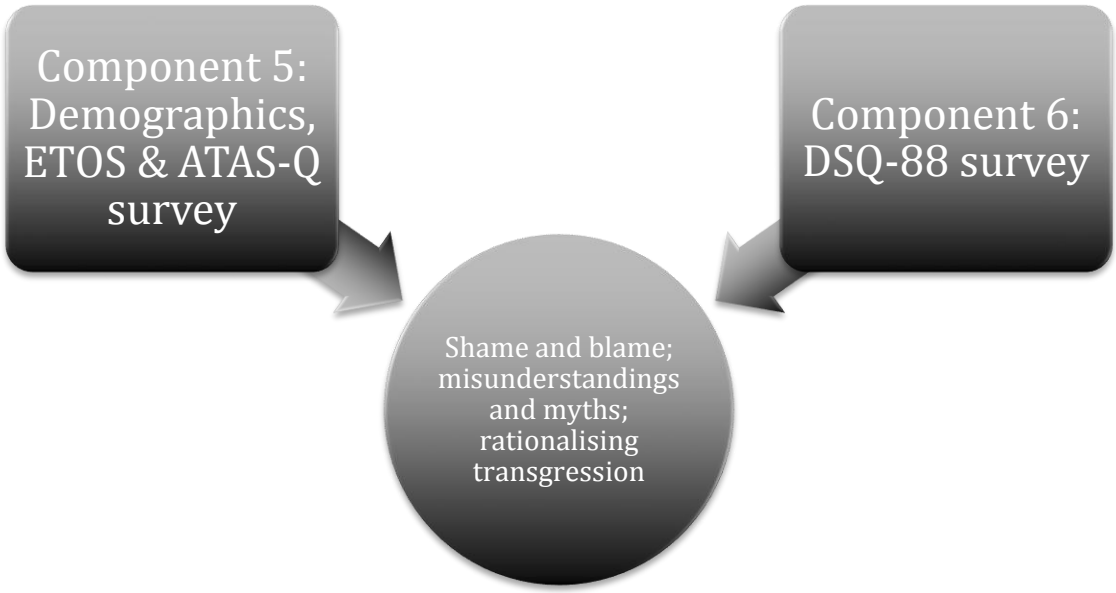


Figure 5.1: Themes arising from quantitative components

Chapter Six: Discussion

"*Rule your feelings, lest your feelings rule you*" Pubililius Syrus (1 B.C.)

Chapter six presents a discussion of the information provided in Chapters 4 and 5.

The Theory of Planned Behaviour [TPB](Ajzen, 1985) may be used to describe both the perceptions about nursing care provided by nurses to people following a suicide attempt as well as the experiences of the recipients of this nursing care.

Qualitative component

The framework of the TPB, (Figure 6.1), identifies the findings arising from the senior nurse qualitative paper presented in Chapter 4 and captures the constructs related to each element of TPB.

The connection between intention and behaviour is not a straight trajectory, but may be derailed by the three aspects of *behavioural beliefs, normative beliefs* and *perceived behavioural control* (Ajzen, 1985). Whilst attitudes toward the behaviour and subjective norms have no direct impact on behaviour, they are solely influenced by intent (Steinmetz, et al., 2011). In the present study the behaviour observed was the nursing care delivered to a person post-suicide attempt, whereas the intention by any nurse was the provision of nursing care.

Ward Culture

Within the construct of behavioural beliefs, Ajzen, (2005) describes the concept of personal positivity or negativity towards the behaviour as the determining factor of the success of the behaviour. This may depend on whether nurses view their role as a nurse and that of nursing positively or negatively. Within the construct of normative beliefs, Ajzen considers subjective norms as the outcome of social or societal norms with their degree of influence impacting upon beliefs (Ajzen, 1991). In the present study, it is important to consider the culture of the ward and whether there is a negative or positive approach to all consumers, irrespective of presenting problems. Understanding ward culture attempts to explain the ethos of the nurses who work within its bounds. Ward cultures can be either positive or negative, with many factors contributing to possibilities. Ward cultures are often described as *the way things are done here* and where culture carriers of the ward, both formal and informal, conduct introductions or orientations to the ward environment.

Tangible aspects of ward culture include adherence to customary, but unwritten, protocols, business meeting schedules, responses to patient and family feedback, provision of nursing care and the expected attitudes and behaviours to others. Codes of conduct are the established sets of principles by which organizations ascribe behaviour (Fry & Johnstone, 2008). As part of a nurse's employment conditions, he or she must adhere to the organization's expectations of the way in which they will comport themselves in a range of circumstances, whereas professional identity relates to how nurses perceive themselves in their role. This may be related to how nurses perceive that they are viewed universally as a

profession, but the consideration for personal (individual) respect and repute are also included in this aspect.

Employment

Employment conditions refer to the position to which employees are recruited and in which they are retained. When nurses are employed to work as nurses, it is accepted that they are able to fulfill the inherent requirements of the role as determined through the advertised position description and recruitment process. One way of assuring this is by validating each nurse's registration with the national registering body, the Australian Health Practitioners Regulation Agency (AHPRA) through the Nursing and Midwifery Board of Australia. Employment conditions also include the employment award (Enterprise Bargaining Agreement) to which they are subject. These agreements mandate pay and classification scales, access to education, leave entitlements and position expectations.

Irrespective of professional standing, each person is exposed to a range of social norms. These inform the ways that individuals are expected to behave in specific circumstances because a number of influencing factors, including religion, age, gender and ethnicity, cannot necessarily be controlled.

Ward resources

To return to Ajzen's (1985) framework, within the domain of control beliefs, perceived behavioural control relates to both the internal and external elements

the nurse accepts as being within or outside their locus of control (Bush, 1988). The component of the present study which explored the Nurse Unit Managers' perceptions of the nursing care provided to people following a suicide attempt introduced the concept of suicide anxiety. It is within this concept that some elements inform the perceived behavioural control aspect of TPB. Since medical and surgical ward environments are considered to be spaces not favourable for the safe care of a suicidal person because of the inherent structural risks, including layout and design, ensures that environment is encompassed within that element and remains outside the control of nurses (Chan et al., 2008; 2009).

Ward resources were identified by NUMs as an issue for nurses when providing care following a suicide attempt. The major resource issues related to staffing, including both quantity and quality, but also the support provided to nurses delivering suicide attempt aftercare. The request for non-nursing staff to observe patients through a process of supervisory monitoring was also included with staffing resources. Nursing knowledge and skills, which may be expressed as capabilities, are also considered to be factors within the perceived behavioural control aspect of the model.

Workplace education

Ward-based education and the provision of evidence-informed practice are often reliant upon the Nurse Educators who are positioned within the organization to assist in the establishment and maintenance of professional capabilities through the delivery of an education calendar. The component of the present study which explored how nurses are supported in their educational endeavours identified

that Nurse Educators are often unable to provide an appropriate level of education and support to nurses delivering suicide attempt aftercare. The lack of timely access to continuing education targeted to the care of this patient group impacts the ability of nurses to deliver contemporary nursing care, irrespective of their intention. Lack of education, professional development and support has been identified in the research literature as a factor contributing to the difficulties facing nurses when providing suicide attempt aftercare (Sun, et al., 2011).

Being present

The Nurse Educators introduced the notion of *presencing*. Presencing is a term they describe as the ability to be present and available to people, assuming all things are considered equal when delivering patient care (McMahon & Christopher, 2011; Stein-Parbury, 2014). Factors which impact on presencing include the recognition of the humanness of nurses: the inability to be perfect. It also recognizes the limiting factors of nurses' physicality and emotionality: the inability to be all for everyone at all times. The inability to be physically present for people occurs due to a number of factors, including other tasks to be completed, ward requirements (including meetings and breaks) and the provision of care for others (Stein-Parbury, 2014). Limits on emotionality arise from factors such as short change-over of shifts (contributing to tiredness), roster changes (night shifts to day shifts), bereavement and loss of patients, ward crises (including medical emergencies and staffing shortages) and conflict (with colleagues, patients and carers) (McMahon & Christopher, 2011; Stein-Parbury,

2014). Stein-Parbury (2014) highlights the importance and value of presencing as an essential aspect of care delivery and of comfort.

The component of the present study which explored the views of the senior nurses identified that they understand the difficulties associated with presencing, which may be exhibited through expressions of resentment, frustration, anger and anxiety. Moreover, the senior nurses introduced the argument that potentially moderating outcomes arise from past experiences. Past experience is not merely limited to that of the professional role as a nurse, but also within familial and social settings, and is also not only limited to personal experiences, but may also be informed vicariously through the experience of others (Ajzen, 1989). Notably, past experience may also contribute to amplified emotions, particularly if the previous experience was negative or had deleterious consequences. Nurses do not have authority to refuse to accept the admission of patients following a suicide attempt, which further contributes to limiting perceived behavioural control.

The outcomes of behavioural beliefs, normative beliefs and perceived behavioural control towards the intention of the behaviour, mean that all patients admitted to hospital because of a suicide attempt would receive the nursing care best matched with their care needs. However, it is evident that a number of contributing factors lead to nursing care which is less than optimal.

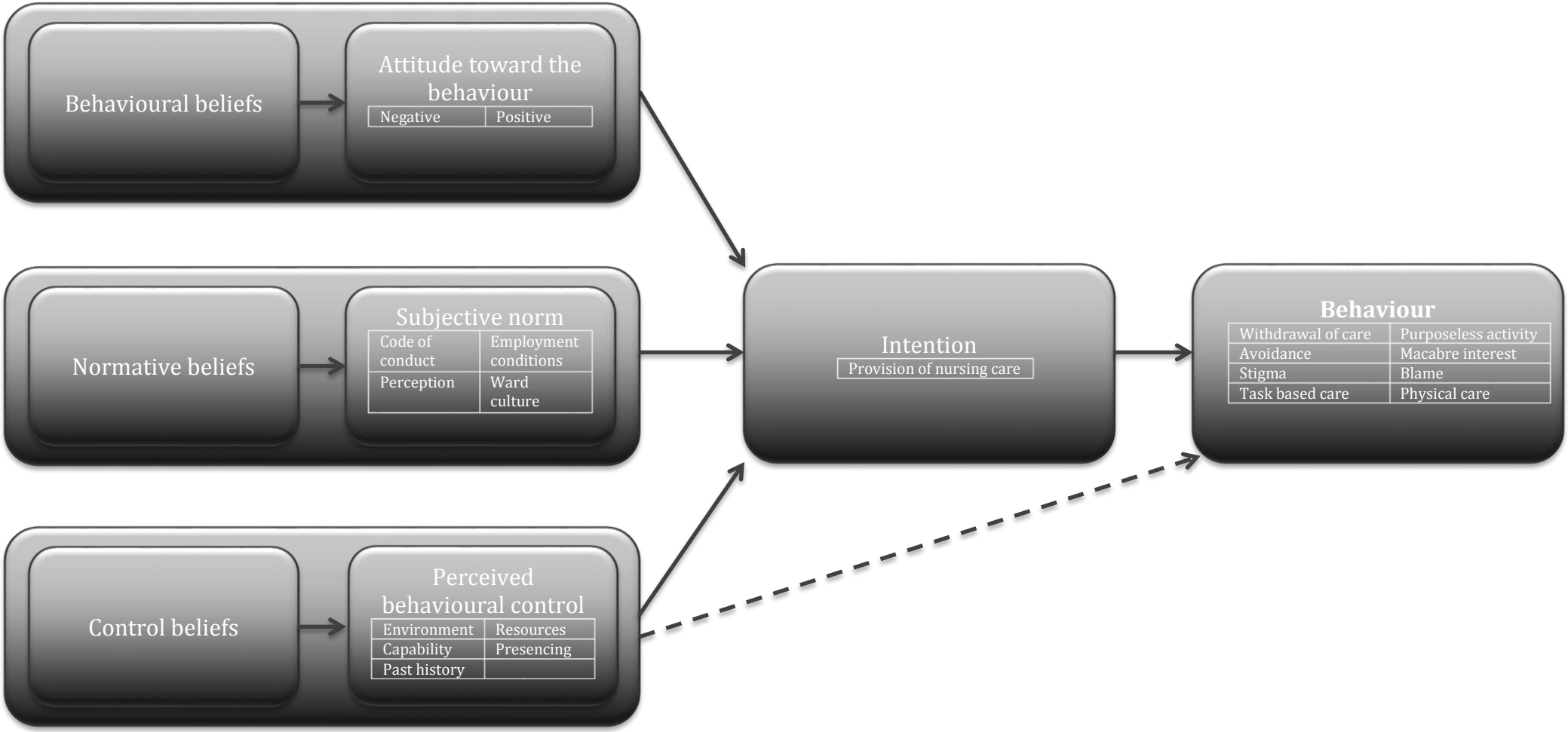


Figure 6.1: Experiences of Nurse Unit Managers, Clinical Nurse Educators and Senior Nurses based on Theory of Planned Behaviour

Figure 6.2 uses a visual representation of the TPB to explain the responses of consumers as demonstrated in the paper presented in Chapter 4. As recipients of nursing care following a suicide attempt, consumers' behavioural beliefs may be anticipated to be negative. Since people who attempt suicide intend to die, it is logical that they experience, as one consumer has described, "anger, frustration and hatred toward the ER team that had saved me; but most of all, I felt fear because I never thought I would wake up" (Silverman, 2001, p.66). Some people have reported that waking after a suicide attempt was "unexpected and painful" (Wiklander, et al., 2003, p.296). These emotions pre-suppose that the hospitalization and subsequent nursing care influence ongoing attitudes towards the behaviour and impact on recovery. Conversely, some consumers may be positive to being admitted to hospital, as this provides an opportunity to access assistance.

Shame and stigma

Internal, self or perceived stigma is a concept that is well discussed within the mental health literature and describes the thoughts and/or emotions that occur when an individual absorbs stereotypical assumptions and applies them to themselves (Drapalski, et al., 2013). If consumers adopt societal attitudes and behaviours (including those of nurses) and believe that they apply to themselves, behaviour becomes driven by the response to the perceived stigma, irrespective of intent.

Shame reflects within individuals their own perceptions about themselves. This is different to internal stigma, where individuals make assumptions about

themselves based on how they believe they are perceived by others (Drapalski, et al., 2013). Nevertheless, internal stigma increases already existing feelings of shame (Oexle, et al., 2017), and has the potential to lead to avoidance by not exposing oneself to others or by not engaging in and withdrawing from communication (Wiklander, et al., 2003). There is a possible connection between subjective norms and the behaviour of consumers. Considering that subjective norms do not directly influence behaviour (Steinmetz, et al., 2011), where intention mediates this, consumers in the present study appeared to protect nurses from their own stigma. As explained earlier, the ward culture naturally impacts

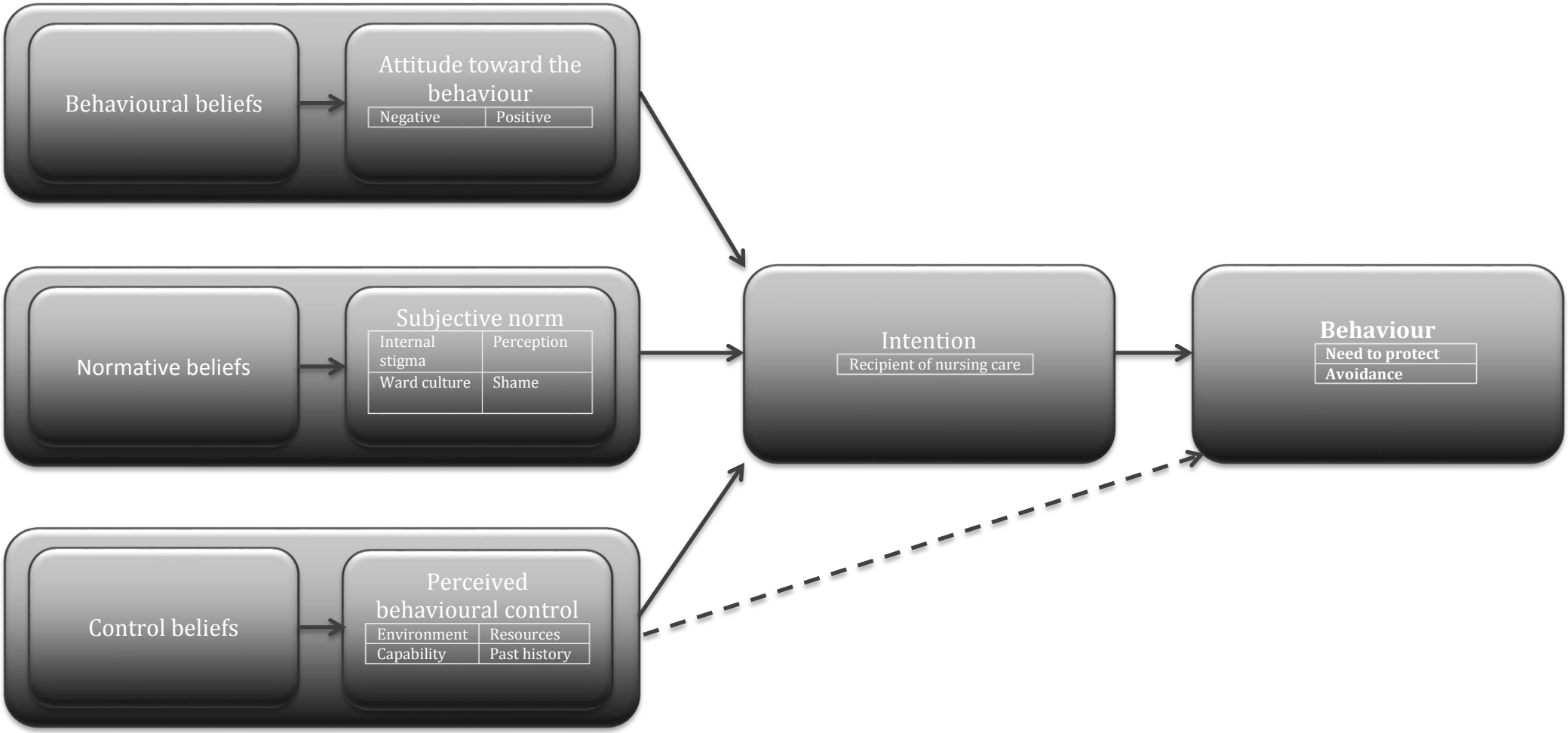


Figure 6.2: Consumer experiences based on Theory of Planned Behaviour

consumers as they are the recipients of care. Whilst not explicit when describing consumer experiences, the communication that occurred between the Emergency Department (ED) nurse and the admitting nurse of the medical ward suggests what are considered to be acceptable practices, forming part of ward and nursing cultures. It is interesting to note that the receiving nurse did not challenge the comments made by the ED nurse, affording tacit approval.

Not all consumers provided examples of negative attitudes towards them, and this may be attributed to the perception that they cannot/should not complain about staff or the care upon which they are reliant (Wiklander, et al., 2003). Lezine (2001, p.32) reports a consumer whose suicide attempt was forestalled retelling his story and describing his admission to a psychiatric hospital as "dehumanizing and demoralizing". Although the consumers in the present study were admitted initially to general hospitals, the experience of one of the consumers (Sharon) could certainly be described in a similar way

Subjective norms comprise a number of components including the ways individuals' impressions are formed, depending upon their social setting and standing, financial wellbeing, employment status, cultural inclusiveness, political leanings, achievement of formal schooling, religiosity, age and gender. For many of these components, only the individual has an understanding of how they might influence intention, because a number of these components are subtle and elusive and not often brought to consciousness.

Environment

The environment plays a significant role in the perceptions of consumers and their adoption of the sick role as an expectation (Faulkner & Aveyard, 2002). The singling out of post-suicide attempt consumers by having them wearing day clothes rather than the ascribed hospital patient uniform of pyjamas and gown may reinforce this perception and further highlights their separateness. The nurses' intention is probably to normalize the experience of being in hospital. However, it establishes a point of difference between patient cohorts, especially when it is considered normal in hospital to wear pyjamas.

Established ward environments are designed to maximize the number of people able to receive treatment at a given time. This impacts on the ability to assure privacy for everyone, and curtains are often the only barriers between beds. This leads to potential breaches of confidentiality, which influences the ability of consumers to engage because they cannot be assured that their conversations will not be overheard (Chan, et al., 2008; 2009). From the consumers' perspectives, it is evident that they felt a need to protect both themselves and nurses, which in turn led to the avoidance of discussions about the issues that brought them to hospital. The need to protect themselves also derived from the avoidance of talking to nurses because they believed that the nurses were unable to understand and assist, and this prevented them from disclosing personal, intimate and sensitive information. However, general medical/ surgical wards provide the appropriate clinical environment to recover from physical health issues.

A person's previous experience with suicide, either personally or within their social interactions, impacts on the way in which they develop and consider their world. If a consumer had previously attempted suicide and had been admitted to a mental health unit, admission to a medical/surgical ward would be an experience associated with the expectations and worldviews of how these wards operate based on any previous experience they had (direct or vicarious).

Suicide attempts typically occur outside the healthcare environment and nurses are required to care for people in hospital who have been admitted after the event has occurred. It is therefore essential that we understand how nurses perceive and provide care for these people (Mishara, 2007). Resources, both internal and external, are available to consumers, with nurses often the conduit to facilitate access to them. A recognized link exists between the ability to access one's coping resources and internal stigma, exacerbating feelings of hopelessness and demoralization, therefore increasing a person's risk of suicide (Scocco, et al., 2016; Clarke & Kissane, 2002). Whilst nurses do not have direct influence on global suicide prevention activities, they facilitate individual suicide prevention through the fostering of connectedness and the reduction of loneliness (Mishara, 2007).

Quantitative component

The framework of the Theory of Planned Behaviour identifies the findings pursuant to the quantitative papers included within Chapter Five (Figure 6.3). It captures the constructs relevant to therapeutic optimism, attitudes towards attempted suicide and the defence styles adopted by nurses when providing suicide attempt aftercare. As described previously, although the *attitude toward*

the behaviour and *subjective beliefs* may remain relatively unchanged, the variable in the TPB model is the *perceived behavioural control*. It is recognized that the best indicator of future behaviour is past behaviour, provided that all three elements remain unchanged (Ajzen, 1991). Behaviour that is repeated irrespective of changes to the variables within the framework is habit-forming and requires deliberate attention to disrupt it (Ajzen, 1991). If this does not occur, the behaviour continues to be repeated and actions are reinforced, despite not necessarily delivering positive outcomes.

Many studies have explored the attitudes of nurses to consumers who have made suicide attempts, with the majority of these undertaken in emergency departments, intensive care units and psychiatric hospitals (Talseth & Gilje, 2011). Globally, suicide attempt aftercare does not offer consistent approaches to the treatment and admission of consumers, with some people discharged directly from the emergency department, some admitted to a medical/surgical ward and some admitted to a psychiatric unit (Bille-Brahe & Löhr, 2004). This is consistent with the practices of the health service within this study. These inconsistencies in approach may lead to nurses' role confusion and their under-estimation of their responsibilities and functions within the broader suicide prevention framework, consequently limiting their ability to engage with this consumer cohort (Hopkins, 2002).

A major component of TPB are the three elements of *attitude toward behaviour*, *subjective norm* and *perceived behavioural control*. This chapter focuses on these elements as preliminary drivers of attitudes and outcomes. As previously

discussed in Chapter 3, since attitudes are derived from the influences of previous experiences, it is important to evaluate the impact and relationship of the three factors and their influence on TPB: therapeutic optimism, attitudes towards attempted suicide and defence styles when considering the attitudes and behaviours of nurses when providing suicide attempt aftercare.

With suggestions that higher levels of therapeutic optimism result in lower levels of restrictive practices, there is cause to reflect on whether high levels of therapeutic optimism equate to positive attitudes to consumers who attempt suicide and the translation of these attitudes into practice (Happell, et al., 2012).

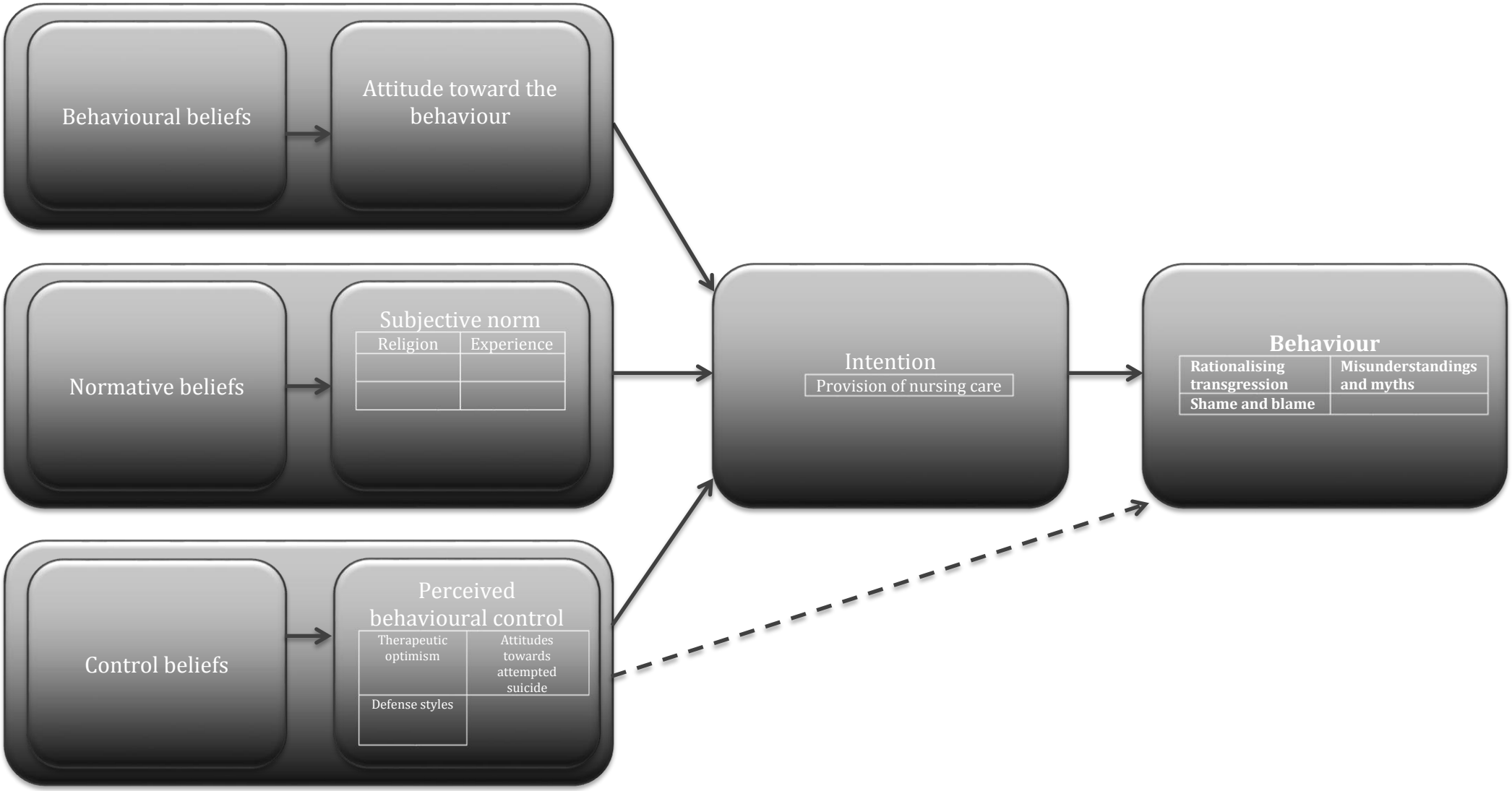


Figure 6.3. Theory of Planned Behaviour and quantitative components of study

Assumptions may be made regarding the levels of therapeutic optimism, attitudes towards suicide attempts and the subsequent reports of consumer satisfaction with the treatment and care they receive. Paradoxically, positive reports from consumers may not indicate positive care, but are instead a reflection of their ability to avoid engagement and disclosure due to nurses' inability to provide suitable care (Bille-Brahe & Löhr, 2004). There is evidence to suggest that therapeutic optimism may be increased through the provision of education and coaching (Byrne, et al., 2006; Rogers, et al., 2013). Given the levels of therapeutic optimism amongst the study participants and their self-reports of limited education on topics relevant to providing care for people following a suicide attempt, education strategies redressing these gaps would be beneficial.

Educational programs and additional qualifications not only enhance therapeutic optimism, but have been shown to have positive outcomes on attitudes towards attempted suicide (Ouzouni & Nakakis, 2013). If educational standing and proficiency are often associated with years of experience, it may be assumed that older nurses would be more therapeutically optimistic and have more positive attitudes towards suicide. However, this is not the case in the present study and this finding is inconsistent with findings from a critical interpretive review undertaken by Talseth & Gilje (2011), who report that older nurses have more positive attitudes towards consumers in the aftermath of a suicide attempt.

How nurses accept, perceive and employ their principles affects the ways in which they interact with consumers and implement care strategies (Cutcliffe & Stevenson, 2007). The concept of religiosity and its relevance to suicide is not a new discussion, with suicide and religious beliefs intersecting over millennia

(Cutcliffe & Stevenson, 2007). One study found that nurses who did not identify with a religion were more positive in their attitudes towards attempted suicide than those who did (Sun, et al., 2007). Other early studies have found that nurses consider suicide rational and justified under certain circumstances (Pallikkathayil & Morgan, 1988; Valente, 2000). These circumstances are typically associated with significant and chronic physical illness.

Defences

Defences are unconscious processes that are used frequently to alleviate the experiences of stress and are a natural part of dealing with psychological distress (Andrews, Singh, & Bond, 1993; Cramer, 2006; Ramkissoon, 2014), with their function being "to protect the person from experiencing excessive anxiety" (Davidson & MacGregor, 1998, p. 967). Defence mechanisms may be activated in response to particular threats or in specific situations (Davidson & MacGregor, 1998). Some authors suggest that as nurses do not typically receive education related to suicide, there exists an inherent occupational stress that may lead to mental and emotional distress, often caused by working with suicidal individuals (Pompili, et al., 2005; 2006). Whilst the 2006 study primarily dealt with issues prevalent within the mental health nursing specialty, similar findings have been reported in studies of the occupational stress experienced by general nurses (Pompili, et al., 2006; Beck, 2011). Pompili, et al. (2006) reported that medical surgical nurses used defences that attributed negative qualities to an object in order to justify feelings of aggression. This is similar to the results reported in Paper 2 presented in Chapter 5.

Although Cramer (2006) describes the use of coping mechanisms to redress

similar triggers, these require awareness and conscious effort to employ them. It has been proposed that individuals may become aware of the defence mechanisms they employ and undertake evaluation of their effectiveness (Hayashi, et al., 2004). Assuming this is correct, actions may be taken to elevate awareness of the defence mechanisms employed, leading to opportunities for defence development, adaption and enhancement of coping mechanisms. Whilst defence mechanisms are referred to as the individual actions adopted to protect the self from situations that cause discomfort (Andrews, Singh, & Bond, 1993; Cramer, 2006), the measurement of defence mechanisms is fundamentally inaccurate because they are unreliable (Cramer, 2006). Nevertheless, the Defense Style Questionnaire (DSQ) measures defence styles that are comprised of defence mechanisms (Andrews, et al., 1993). Defences themselves are established and utilized during various stages of human development that change and adapt as maturity develops (Cramer, 2015). As the DSQ reflects the personality characteristics of individuals rather than their mental state, the results should remain relatively stable over time (Hayashi, et al., 2004). Repeated use of any one defence leads to habituation and reliance on that same defence whenever anxiety is experienced relative to the originating trigger (Andrews, et al., 1993). This is pertinent because according to the TPB, habits are formed when there is no change to *attitudes toward behaviour, subjective beliefs* and *perceived behavioural control* (Ajzen, 1991).

The nurses in the present study indicated overall that they were therapeutically optimistic, albeit only moderately. However, when correlated with their attitudes towards attempted suicide and the use of defence styles, the results appear to

indicate the presence of feelings of martyrdom. The expression of martyrdom in nurses is not evident in the peer-reviewed literature. However, it is expressed in a number of blogs accessible on the Internet: https://thoughtcatalog.com/hilary-thomas/2014/05/we-need-to-stop-glorifying-nurses/ . These conversational blogs display nurses' comments that refer to them going beyond what is required for patients and offering selflessly of themselves and that this is what is required for their role. People other than nurses also engage in these conversations, either supporting or decrying the nurses' responses. Conversely, these blogs also indicate the presence of negative connotations that express a *woe is me* attitude, in that nurses repeatedly complain about their job, that it is one that must be endured for the sake of others. An excerpt from this blog reads:

> *And while I am up at night watching my patient, the doctor is sleeping in his bed. Yes that is right. No hospitalist for the oncology patient. Yes the doctor gives the order but if something is seriously wrong with my patient, it is my job to put the pieces together, to call the doctor and give him a clear picture of what's going on because he is not there to assess. I am waking him out of her/his sleep and already know exactly what I am going to ask for. I have eyes on everything.*

Nurses complain about the unsociable hours of their role and that they detract from being available for family time, that they are exposed to blood, pus, faeces, urine and sputum, that they meet ungrateful people and that they have to keep a 'watch' on the doctors. These notions can be ascribed to the *self-sacrificing* defence styles that are statistically significant between the ATAS-Q and DSQ-88.

The defences in the *self-sacrificing* factor are *pseudo-altruism, denial* and *reaction formation.*

Pseudo-altruism is the anticipated expectation of recognition for undertaking tasks for the perceived outward benefit of others and is typically selfishly motivated (Feigin, et al., 2014). This connects very closely with the perceptions of nursing "martyrs" described earlier. Denial is the defence that prevents people from acknowledging and recognizing the existence of emotions arising from particular circumstances (Vakin, 2008). It results in the blaming and shaming theme exhibited by the nurses towards consumers in the second paper presented in Chapter 4. Reaction formation is the defence that, irrespective of internal beliefs, values and emotions, the behaviour exhibited is diametrically opposed to their opinions, principles and feelings (Vakin, 2008). Ultimately, the nurses in this study would prefer not to provide care for people following a suicide attempt, but they do it anyway, because doing what no others will do reaffirms their status as a nurse.

When considering the behaviours exhibited by nurses through the themes expressed in the papers presented in Chapter 5, each of them reveals a negative outcome for consumers. Since the purpose and subsequent *intention* of nursing is to perform caring activities that contribute to the health, wellbeing and recovery of individuals, either sick or well (Henderson, 1978), the limitations imposed through the expression of attitudes, therapeutic optimism and defence mechanisms hinder the ability to provide the necessary aid. Therefore, the *perceived behavioural control* for nurses in these studies had supplanted their intention to provide nursing care that is unconditional.

Chapter Summary

The theory of planned behaviour (Ajzen, 1985) guided the discussion of the themes identified in this chapter. Content was drawn from data presented in papers from Chapters 4 & 5 as well as data collected that have not been submitted for publication. The next chapter concludes the thesis. It includes implications for practice and recommendations for further research.

Chapter Seven: Conclusion, Implications and Recommendations

The aim of the study was to explore the factors that influence the behaviours of nurses working in acute care settings and identify their skills and knowledge in relation to working with people following a suicide attempt. The research sought to examine a number of questions:

1. **Does anxiety explain the formation of attitudes and behaviours of nurses when providing suicide attempt aftercare?**

Anxiety is only one factor in the formation of the attitudes and behaviours of nurses who provide suicide attempt aftercare. The Theory of Planned Behaviour (Ajzen, 1985) attributes attitude formation to three antecedents, *behavioural beliefs, normative beliefs* and *control beliefs* (Ajzen, 2005). Salovey and Mayer (1990) propose two perspectives on emotions. One is that emotions are viewed "as disorganized interruptions of mental activity, so potentially disruptive that they must be controlled" (Salovey & Mayer, 1990, p.185). The alternative perspective proposes that emotions, because of their adaptive capabilities, are in fact responsible for thought and action (Salovey & Mayer, 1990). One such emotion, a trigger for the "fight or flight" response, anxiety may be viewed in either a positive or negative light (Cloninger, 1988). By extension, suicide anxiety may trigger a similar response, depending on whether it enables nurses to engage in caring work or leads to maladaptive reactions to being required to provide suicide attempt aftercare. Suicide anxiety is formed when three significant elements are present: not being person-centred, risk, and

communication (Figure 7.1). Each is comprised of three sub-elements. Risk concerns the environment, resources and capability, whilst sub-elements of communication are avoidance, macabre interest and stigma. Anxiety cannot be attributed in isolation to the formation of attitudes of nurses when providing suicide attempt aftercare. The other contributing factors to nurses developing attitudes towards attempted suicide certainly include all of the relevant propositions that aid in forming beliefs, as identified by the TPB.

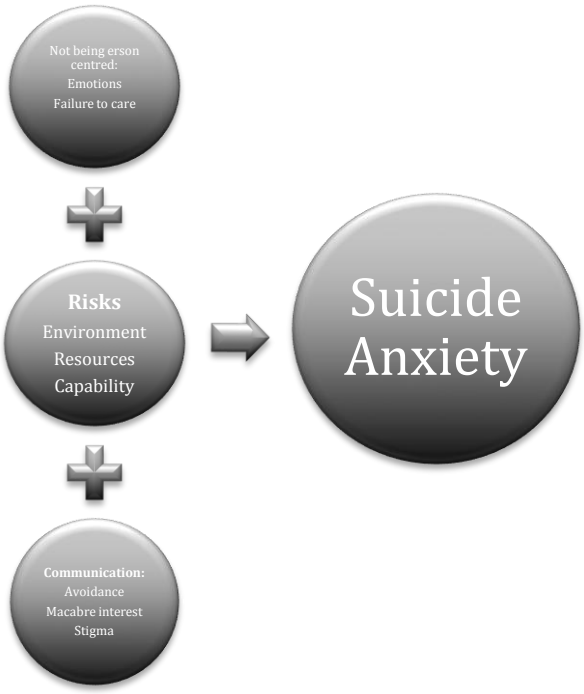


Figure 7.1: Suicide anxiety

2. What are the knowledge, skills and attitudes of nurses working in acute care settings when working with people following a suicide attempt and how are they explained?

The nurses who participated in the present study acknowledged that they do not have the requisite skills and knowledge and indicated their preference for further education in the specialist field. The consumers also recognized that

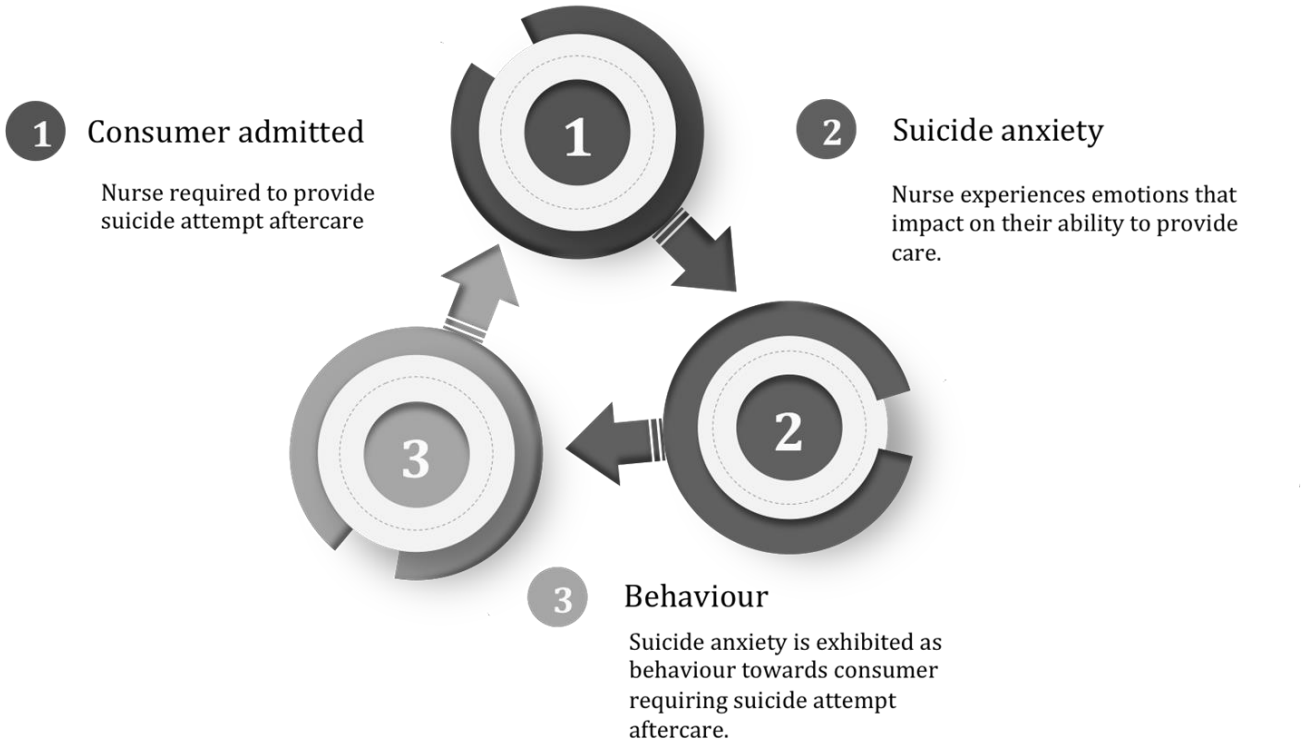
medical and surgical nurses do not have the requisite knowledge and skills to provide therapeutic nursing care. Conversely, the nurses reported moderately positive therapeutic optimism and attitudes towards attempted suicide. However, the reporting of their unconscious defence usage confounds the results of these instruments. The correlations of therapeutic optimism, attitudes towards attempted suicide and defence styles indicate that ultimately nurses do not want to provide care for consumers admitted to their wards for suicide attempt aftercare. Nevertheless, they undertake this task begrudgingly and with little of themselves invested in the care for these consumers.

3. What unit culture exists where people are treated following a suicide attempt?

Knowledge of the unit culture was not an explicit outcome of the study. The quantitative data provided anonymity for the respondents, as there was no requirement for them to identify which ward they worked in. However, conclusions may be drawn as to the ward ethos from both the qualitative and quantitative aspects of the research. The Nurse Unit Managers described the ward busyness and concerns expressed by nurses when providing suicide attempt aftercare. Much of the behaviour portrayed by nurses has been explained through the use of the term “suicide anxiety”. The consumers reported receiving positive attitudes and care from nurses, with the caveat, that they did not expect the nurses in these environments to be adequately prepared to provide suicide attempt aftercare. The anomaly of attitudes recounted by one of the consumers relates to the episode describing the handover communication between nurses. It may be assumed that the nurse receiving the consumer for

care was either of the same opinion as the Emergency Department nurse or that she felt disempowered and inhibited to redress the language used during this interaction. However these assumptions may be imprudent, as according to the Theory of Planned Behaviour (Ajzen, 2005), the suicide anxiety experienced by nurses is a variable that impacts on *perceived behavioural control*. Therefore, behaviours exhibited arising as a result of suicide anxiety are repeated each time a consumer is admitted following a suicide attempt, reinforcing the cyclical nature of the anxiety response because the inherent emotion exists in the nurse (see Figure 7.2).

This reinforcing mechanism may lead to habit-forming behaviours, ensuring that the behaviours of the nurses are repeated each time they provide suicide attempt aftercare. These results concur with Ajzen (1991), who believes that if opportunities and resources are available to a person and the intention to perform the behaviour is present, the behaviour that is desired is what is achieved. However, some behaviour, such as racism, is informed by implicit attitudes and is more likely to not be under volitional control (Ajzen, 2005). Given that these behaviours may be self-reinforcing, it is feasible to also conclude that role modelling of abject attitudes and behaviours may occur, further influencing new generations of nurses.



* The behaviour is repeated because suicide anxiety is present every time a consumer is admitted following a suicide attempt.

Figure 7.2: Model of suicide anxiety reinforcing behaviour

4. Do nurses working in acute care settings have more negative attitudes towards people who present following suicide attempts on multiple occasions?

Given the moderately positive results of the ATAS-Q reported in Chapter 5, it could be concluded that, irrespective of the reason for a person's admission to their hospital ward, consumers receive care that is unconditional. As previously discussed, the reaction formation defence is likely to see nurses provide care that outwardly appears positive as they seek to adopt an opposing stance to what is a personally and professionally abhorrent belief (Baumeister, Dale & Sommer, 1998). Therefore, if consumers are admitted to hospital on multiple occasions following suicide attempts, it may be concluded that the behaviours exhibited by

the nurses are outwardly positive. Medical and surgical nurses who provide suicide attempt aftercare are often placed in difficult situations. Whilst it may be recognized by other nurses that there are certain groups of people or conditions to which a nurse may prefer not to be allocated, the defences adopted by nurses may not allow them to seek alternative assignments. The self-sacrificing nature of nurses means that they recognize that if they do not provide care, the task will fall to a colleague or the patient will not receive care, contributing to feelings of guilt by the nurse. This, in turn leads to care burden and to a disaffected workforce, contributing to increased burnout, poor performance, decreased job satisfaction and retention issues. Whilst not all of these outcomes could be solely attributed to providing suicide attempt aftercare, the unconscious experience of the cognitive dissonance of providing care whilst not wanting to do so increases stress levels of nurses, ensuring that their stress tolerances remain constant. The increasing rates of suicide and attempted suicide mean that, irrespective of a nurse's practice specialty, they will at some point care for someone who is or has been suicidal. Attitudes towards attempted suicide are influenced by a number of internal and external factors.

Strengths and limitations of the study

The adoption of a multimodal approach to the research has meant that the strengths of each research methodology have been able to be adopted; however, it also means that the weaknesses inherent in qualitative and quantitative research are also evident. Interviews held with Nurse Unit Managers, Clinical Nurse Educators, Senior Nurses and consumers delivered a contextual and experiential understanding of their thoughts, expectations of care and perceived

and real barriers to working with people following a suicide attempt. One perspective that was not sought was that of the nurses who provide this care. This was a deliberate decision, made because the nurses were providing their context via the survey. However, this has restricted the ability to source directly nurse perceptions and wisdom in an area in which they are significant stakeholders. Some criticism by nurse participants was the length of the survey, both in the number of questions and the time required to complete it. This may have influenced other nurses to withhold their participation.

Although suicide attempts occur in increasing numbers, some people do not seek assistance from healthcare providers, or if they do, may not require hospitalization. This means that hospital environments do not always have consumers admitted to their care who require suicide attempt aftercare. During the data collection period, there were times where there were no consumers in the wards to which ethics approval for the study had been granted who could be recruited for to participate.

With the advent of critical suicidology, the need to understand the personal contexts of individuals is foregrounded. This includes their experiences of what defines them, incorporating their culture (Bantjes & Swartz, 2017). This understanding assists researchers and policy makers with the advent of newer, targeted suicide prevention strategies (Bantjes & Swartz, 2017). Australia is a country comprising many cultures, originating from many countries around the globe. This is also true of the local community in which this study was conducted. With a country comprised of many cultures, in order to develop appropriate suicide prevention activities, it must be recognized that the risk of suicide of

immigrants tends to reflect that of their originating country (De Leo & Spathonis, 2004). Contemporary suicidologists approaches to the identification of suicide risk and suicide prevention activities that are developed and encompass Aboriginal Australians miss the cultural specificities of this unique population (Tatz, 2002). Aboriginal and Torres Strait Islander people were not excluded from the study, but they were not identified during the data collection stage.

When interviewing consumers for this study, cultural identity was not explored, and this may be considered to be a limitation. However, given that the purpose of interviewing consumers was not to ascertain what preceded their suicide attempt but to explore their experiences of nursing care following their suicide attempt, cultural identity need not be explored. Alternatively, it could be considered that consumer views of nursing care could be interpreted through a cultural lens (Stein-Parbury, 2014).

Another limitation of the study was a lack of observation of the interactions between nurses providing and consumers in receipt of suicide attempt aftercare. Observation may provide greater depth to the discussion and offer deeper insights into the experiences of participants.

That the study was confined to one health service in one state means that assumptions drawn may not be relevant to other organizations.

Recommendations for Nursing Practice and Education

Two major recommendations for nursing practice and education arise from this study:

1. Health services should advance the professional development of nurses, and provide necessary support structures to ensure access to education.
2. Anxiety ameliorating education for nurses should be developed and provided, encompassing both post-graduate nurses and those in undergraduate nurse preparation courses.

Employers need to recognize the value of investing in nurses professionally, for the benefit of consumer and healthcare outcomes. It is recognized that nursing is a physically, intellectually and emotionally demanding profession (Horton-Deutsch & Sherwood, 2017). Given the overwhelming impact of suicide anxiety on nurses' ability to provide suicide attempt aftercare, efforts to implement strategies to redress this potentially debilitating emotion are essential. The results of this study show that medical and surgical nurses are unlikely to receive education about attempted suicide and associated mental health assessment and intervention skills. However, this supports the assertion that there is an urgent need for these nurses to receive this germane education. This nursing cohort exhibits negative attitudes, which can be rectified through the provision of mental health education resulting in improved attitudes (Muehlenkamp, et al., 2013). One education program considered suitable to increase knowledge of mental health issues and the development of subsequent strategies is Mental Health First Aid (Bond, et al., 2015). Although this program is readily available in the university sector for nursing students, it has been little

utilized in the nursing workforce (Bond, et al., 2015). Provision of education such as that provided by this program should be embedded in the professional development frameworks of health services. This will ensure nurses are supported in the workplace to provide the requisite care for this patient cohort. In a review of undergraduate nursing curricula, Happell (2010) identified the lack of mental health specific content. Given the prevalence of mental health issues amongst the broad Australian community, specific mental health education, incorporating suicide attempt aftercare at both undergraduate and postgraduate levels is essential for the provision of holistic nursing care (Happell, 2014). This would ensure a health sector-wide quality care service, rather than one which contains pockets of quality care. The commitment to deliver dedicated mental health education to enhance the skills and knowledge of nurses cannot be made lightly. It will require a significant investment of time, resources and money, including professional development leave and capable educators, proficient in delivering this specialist tutelage. In the first instance, the CNEs should receive this education, and then showcase their knowledge to their respective clinical areas.

The Nurse Unit Managers are in unique positions within health services. They are well placed to act as conduits for information dissemination both to their direct reports and from their managers. Specialist education needs to be provided to NUMs in order for them to be confident in the capabilities of their staff when providing suicide attempt aftercare. They also need to be aware of how to support the wellbeing of their staff, given the identified risks associated with care provision of the suicidal individual in a medical/surgical ward.

Educators Horton-Deutsch and Sherwood, (2017) write of the current limitations in nursing education that thwart the human and emotional factors that have a bearing on nurses in their roles (Horton-Deutsch & Sherwood, 2017). This implies that an often-overlooked area of nursing education is the lived experience of nurses and how it relates to their delivery of care. Therefore, an anxiety ameliorating approach to nursing education is suggested (Figure 7.3), the components of which must include resilience-building capabilities, emotional intelligence and mindfulness. Each of these components offers strategies that lead to greater conscious awareness of managing not only suicide anxiety, but anxiety in general (Wang, et al., 2016).

Figure 7.3: Anxiety ameliorating approach to nursing education

Whilst there are evidence-based therapies that are effective in the management of anxiety, in the case of suicide anxiety among nurses there is no need to start

them on a therapeutic journey; instead they can utilize aspects of the techniques developed in these therapies. Since evidence-informed techniques provide personal capabilities to manage anxiety, the ability to adopt and adapt thoughts, feelings and emotions when under stress is indicative of conscious awareness and competence (Grant & Kinman, 2014). Nurses need to be exposed to these techniques in their undergraduate preparation and be encouraged in their ongoing use throughout their professional lives.

Resilience provides the opportunity for individuals to salvage normalcy following episodes of stress or distress (Grant & Kinman, 2014). In particular when confronted with the requirement to provide suicide attempt aftercare and the emotional response of nurses evidenced as suicide anxiety, resilience permits the nurse to function at the levels required to facilitate care. There are recognized correlations between defence mechanisms and emotional intelligence, with awareness and understanding of emotions being linked with positive psychological adjustment (Pellitteri, 2002). This may assist with nurses' use of adaptive defences. In order to build emotional intelligence, education must focus on the five pillars: establishment of self-awareness, empathy, self-regulation, motivation and social skills (Goleman, 2009).

Recommendations for further research

This study has proposed the existence of 'suicide anxiety' as a driver for the ways in which nurses limit their ability to provide holistic care in the aftermath of a suicide attempt. Further examination of this construct is required in other specialties in nursing and in other disciplines to further scrutinize this theory. Observational studies exploring the actual interactions that occur between

nurses and consumers admitted for care following a suicide attempt may assist with the recognition of attitudes and their correlation with behaviour. Further work examining the adoption of defence styles by nurses is suggested, with an exploration of the adoption of anxiety-ameliorating education as a strategy underpinning all components of nursing education. An educational and/or therapeutic intervention study might also be helpful in determining best methods for building capacity among nurses. Implementing and evaluating practice development activities will assist in creating environmental changes to support the care of people following a suicide attempt.

Reflections

As a senior nurse within the organization, albeit without direct authority and governance of the areas described in this study, I have a measure of influence amongst my colleagues. In areas within my domain, I have the autonomy to implement changes I consider essential to enhance the outcomes of nursing care. Outside my sphere, my direct authority is limited. However, I have the opportunity to influence my senior nurse colleagues, the Directors of Nursing and the Chief Nursing Officer to consider how the needs of a vulnerable patient population may best be met. In addition, this sphere of influence may extend beyond my nursing specialty. It is not one constrained by wards or units, as the mental health outcomes of consumers and the care provided by nurses are not unique to the mental health arena. The specific mental health and suicide attempt aftercare education required by over 7000 nurses in this organization will require a commitment beyond my operational and professional influence. However, I will continue to add my voice to the increasing demands of nurses

and academics for enhanced mental health undergraduate education, and I will reaffirm my commitment to act as a professional advocate on behalf of my nursing colleagues who are desperately seeking support and specialist mental health education in the healthcare environment.

Chapter Summary

This chapter has presented the results against the original aims of the study, drawn conclusions and made recommendations for nursing practice, education and research.

Overall, the focus of this research was to gain an insight into the attitudes and behaviours of medical/surgical nurses who provide suicide attempt aftercare. In order to achieve this, it was essential to develop an appreciation of the perspectives of Nurse Unit Managers, Clinical Nurse Educators, Senior Nurses and consumers who have attempted suicide and been admitted to a medical or surgical ward. In addition, the nurse participants offered insights into their roles and the challenges posed by providing suicide attempt aftercare. The participants' pragmatic worldviews informed by their experiences and the context of the care environment to which they have been exposed have helped to gain understanding of the factors that not only influence the formation of attitudes but also the expression of nurses' behaviours towards people following a suicide attempt.

Appendices

Appendix 1: Ethics Approval

C

Research Directorate
Southern Health
Monash Medical Centre
[redacted]

02 April 2013

A/Prof Wendy Cross
School of Nursing and Midwifery
Head of School
Monash University
[redacted]
Wellington Road
Clayton Vic 3800

Dear Researcher,

Research Project Application No. 12373B: An Investigation into the Attitudes, Behaviours and Interactions of Nurses in Acute Care Settings when Providing Suicide Aftercare

The Committee considered the revised application and responses dated 04 January 2013 at its meeting on 21 March 2013. It was resolved that this project be approved subject to the following conditions. The responses are to be reviewed outside of the Committee by the Medical Administrator and Research Directorate staff.

1. Submission of a response to the following Ethical Issues:

a. submisison of the student researchers curriculum vitae;

b. submission of a revised Participant Information and Consent Form with the following amendments:

i.it is suggested that the researchers consider inserting some information about empathy as the information for nurses could come across as a bit forceful;

ii. in the information for participants, state how the participant's participation relates to the nurse's participation.

Should you have any queries, please contact me on 9594 4605.

Yours sincerely
[redacted]

DEBORAH DELL
Manager, Human Research Ethics Committees
Research Directorate

Please Note: All responses/correspondence must be submitted in hard copy with the project number and title

Monash Medical Centre, Clayton | Monash Medical Centre, Moorabbin | Kingston Centre Warrigal Road | Dandenong Hospital David Street | Casey Hospital Kangan Drive | Community-based services across the South East
[redacted]

Appendix 2: Nurse Information Sheet/ Consent

MonashHealth MONASH University

Participant Information Sheet/Consent Form

Health/Social Science Research - *Adult providing own consent*

Monash Health – Clayton, Dandenong & Casey

Title	*An investigation into the attitudes, behaviours and interactions of Nurses in acute care settings when providing suicide aftercare.*
Coordinating Principal Investigator/ Principal Investigator	*Professor Wendy Cross*
Associate Investigator(s)	Dr Kay McCauley Jakqui Barnfield
Location	*Clayton, Dandenong & Casey Hospitals*

Part 1 What does my participation involve?

1 Introduction

You are invited to take part in this research project, which is called '*an investigation into the attitudes, behaviours and interactions of Nurses in acute care settings when providing suicide aftercare*'. You have been invited because you are a Nurse who is professionally and/or operationally responsible for Nurses who work in a clinical area in which suicide aftercare may be provided.

This Participant Information Sheet/Consent Form tells you about the research project. It explains the processes involved with taking part. Knowing what is involved will help you decide if you want to take part in the research.

Please read this information carefully. Ask questions about anything that you don't understand or want to know more about. Before deciding whether or not to take part, you might want to talk about it with a relative, friend or local health worker.

Participation in this research is voluntary. If you don't wish to take part, you don't have to.

If you decide you want to take part in the research project, you will be asked to sign the consent section. By signing it you are telling us that you:
- Understand what you have read
- Consent to take part in the research project
- Consent to be involved in the research described
- Consent to the use of your personal and health information as described.

You will be given a copy of this Participant Information and Consent Form to keep.

2 What is the purpose of this research?

The aim of this project is to explore the factors that influence the behaviours of nurses working in acute care settings and their skills, knowledge and empathy in relation to working with people following a suicide attempt.

Findings of this research will provide significant information that will help to develop a clearer understanding of the attitudes, behaviours and interactions of nurses as well as the needs of consumers who require suicide aftercare. Moreover, it will provide information to inform the educational requirements of nurses when working with people who are receiving suicide aftercare. It is hoped that findings of this research will benefit nurses with a clearer understanding about the knowledge, skills, attitudes and behaviours required when working with people who require suicide aftercare.

On average 6 people suicide each day in Australia, with estimates that incidents of attempted suicide are 23 times greater than suicides (De Leo, Cerin, Spathonis, & Burgis, 2005), with some people making multiple attempts. Of these people who attempt suicide and do not die, many require hospitalisation; as a result nurses in all subspecialties of practice are likely to provide suicide aftercare for someone at some point in their career (Lakeman, 2010).

The results of this research will be used by the researcher Jakqui Barnfield to obtain a Doctor of Philosophy degree.

3 What does participation in this research involve?

Written consent will be obtained prior to interviews. The interviews will last between 45 minutes to an hour and can be conducted at a place and time that is suitable for participants. The interviews will be tape-recorded and then transcribed with participant's permission. Participants will have the opportunity to review the draft of the transcript. To maintain confidentiality participant's names and their place of work will be assigned pseudonyms.

This research project has been designed to make sure the researchers interpret the results in a fair and appropriate way and avoids researchers or participants jumping to conclusions.

There are no costs associated with participating in this research project, nor will you be paid. However, you may be reimbursed for any reasonable travel, parking, meals and other expenses associated with the research project visit.

4 Other relevant information about the research project

In total it is anticipated that 484 people will participate in the research. These may be; Registered Nurses, Enrolled Nurses, People who have attempted suicide, Nurse Educators, Nurse Unit Managers, Directors of Nursing & Senior Nurse Advisor. Within Monash Health, 2 wards from each hospital at Clayton, Dandenong and Casey will be involved.

All interviews will be conducted using a digital audio recorder enabling transcription of the voice recordings to be undertaken by the researcher.

5 Do I have to take part in this research project?

Participation in any research project is voluntary. If you do not wish to take part, you do not have to. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage.

If you do decide to take part, you will be given this Participant Information and Consent Form to sign and you will be given a copy to keep.

Your decision whether to take part or not to take part, or to take part and then withdraw, will not affect your ongoing relationship with the researchers.

6 What are the possible benefits of taking part?

We cannot guarantee or promise that you will receive any benefits from this research; however, possible benefits may include the development and provision of education related to the provision of suicide aftercare.

7 What are the possible risks and disadvantages of taking part?

You may feel that some of the questions we ask are stressful or upsetting. If you do not wish to answer a question, you may skip it and go to the next question, or you may stop immediately. If you become upset or distressed as a result of your participation in the research project, the research team will be able to arrange for counselling or other appropriate support. Any counselling or support will be provided by qualified staff who are not members of the research team. This counselling will be provided free of charge.

8 What if I withdraw from this research project?

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9 Could this research project be stopped unexpectedly?

This research project may be stopped unexpectedly for a variety of reasons. These may include reasons such as the researcher ceasing her academic studies.

10 What happens when the research project ends?

A summary report of the overall findings of the project will be sent to the participating wards and will available to all participants on request.

Part 2 How is the research project being conducted?

11 What will happen to information about me?

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Your information will only be used for the purpose of this research project and it will only be disclosed with your permission, except as required by law.
It is anticipated that the results of this research project will be published and/or presented in a variety of forums. In any publication and/or presentation, information will be provided in such a way that you cannot be identified. Any information obtained for the purpose of this research project that can identify you will be treated as confidential and securely stored. It will be disclosed only with your permission, or as required by law.

In accordance with relevant Australian and/or Victorian privacy and other relevant laws, you have the right to request access to the information about you that is collected and stored by the research team. You also have the right to request that any information with which you disagree be corrected. Please inform the research team member named at the end of this document if you would like to access your information.

12 Complaints and compensation

If you suffer any distress or psychological injury as a result of this research project, you should contact the research team as soon as possible. You will be assisted with arranging appropriate treatment and support.

13 Who is organising and funding the research?

This research project is being conducted by Jakqui Barnfield. No member of the research team will receive a personal financial benefit from your involvement in this research project (other than their ordinary wages).

14 Who has reviewed the research project?

All research in Australia involving humans is reviewed by an independent group of people called a Human Research Ethics Committee (HREC). The ethical aspects of this research project have been approved by the HREC of Monash Health. This project will be carried out according to the *National Statement on Ethical Conduct in Human Research (2007)*. This statement has been developed to protect the interests of people who agree to participate in human research studies.

15 Further information and who to contact

The person you may need to contact will depend on the nature of your query. If you want any further information concerning this project or if you have any problems which may be related to your involvement in the project, you can contact Jakqui Barnfield on 0433 799 855 or any of the following people:

Research contact people

Name	Professor Wendy Cross
Position	Head of School Nursing and Midwifery
Telephone	[redacted]
Email	[redacted]

Name	Dr Kay McCauley
Position	Senior Lecturer
Telephone	[redacted]
Email	[redacted]

If you have any complaints about any aspect of the project, the way it is being conducted or any questions about being a research participant in general, then you may contact:

Reviewing HREC approving this project and this research and complaints contact details

Reviewing HREC name	Monash Health Human Research Ethics Committee B
Name	Ms Malar Thiagarajan
Position	Director, Research Services
Telephone	[redacted]

Appendix 3: Consumer Information Sheet/ Consent

MonashHealth MONASH University

Participant Information Sheet/Consent Form

Health/Social Science Research - *Adult providing own consent*

Monash Health – Clayton, Dandenong & Casey

Title	*An investigation into the attitudes, behaviours and interactions of Nurses in acute care settings when providing suicide aftercare.*
Coordinating Principal Investigator/ Principal Investigator	*Professor Wendy Cross*
Associate Investigator(s)	Dr Kay McCauley Jakqui Barnfield
Location	*Clayton, Dandenong & Casey Hospitals*

Part 1 What does my participation involve?

1 Introduction

You are invited to take part in this research project, which is called '*an investigation into the attitudes, behaviours and interactions of Nurses in acute care settings when providing suicide aftercare*'. You have been invited because you are a person who is currently receiving suicide aftercare from nurses who have consented to participate in this project.

This Participant Information Sheet/Consent Form tells you about the research project. It explains the processes involved with taking part. Knowing what is involved will help you decide if you want to take part in the research.

Please read this information carefully. Ask questions about anything that you don't understand or want to know more about. Before deciding whether or not to take part, you might want to talk about it with a relative, friend or local health worker.

Participation in this research is voluntary. If you don't wish to take part, you don't have to.

If you decide you want to take part in the research project, you will be asked to sign the consent section. By signing it you are telling us that you:
- Understand what you have read
- Consent to take part in the research project
- Consent to be involved in the research described
- Consent to the use of your personal and health information as described.

You will be given a copy of this Participant Information and Consent Form to keep.

2 What is the purpose of this research?

The aim of this project is to explore the factors that influence the behaviours of nurses working in acute care settings and their skills, knowledge and empathy in relation to working with people following a suicide attempt.

Findings of this research will provide significant information that will help to develop a clearer understanding of the attitudes, behaviours and interactions of nurses as well as the needs of consumers who require suicide aftercare. Moreover, it will provide information to inform the educational requirements of nurses when working with people who are receiving suicide aftercare. It is hoped that findings of this research will benefit nurses with a clearer understanding about the knowledge, skills, attitudes and behaviours required when working with people who require suicide aftercare.

On average 6 people suicide each day in Australia, with estimates that incidents of attempted suicide are 23 times greater than suicides (De Leo, Cerin, Spathonis, & Burgis, 2005), with some people making multiple attempts. Of these people who attempt suicide and do not die, many require hospitalisation; as a result Nurses in all subspecialties of practice are likely to provide suicide aftercare for someone at some point in their career (Lakeman, 2010).

The results of this research will be used by the researcher Jakqui Barnfield to obtain a Doctor of Philosophy degree.

3 What does participation in this research involve?

To determine your eligibility to participate in the research, the researcher will approach you and inform you of the research and ask a number of questions (known as the Evaluation to Sign Consent). These include;

1. Determining if you are alert and able to communicate with the researcher
2. List any risk from study participation
3. Identify what is required as part of study participation
4. Explain the process for consent withdrawal
5. Identify procedures to follow should distress or discomfort occur as a result of the study.

Successful completion of Evaluation to Sign Consent requires potential participants to respond accurately to the above items. If any item is answered incorrectly, the researcher may prompt by repeating the information once, and then repeat the question a second time. If answered incorrectly again, informed consent will be delayed for 24 hours. If at the second time and item is answered incorrectly informed consent will not be obtained from that patient.

Written consent will be obtained prior to interviews. Your participation in this study will allow for opportunity to make comments during an individual interview. The interviews will last between 30-45 minutes and can be conducted at a place and time that is suitable for participants. The interviews will be tape-recorded and then transcribed with participant's permission. Participants will have the opportunity to review the draft of the transcript. To maintain confidentiality participant's names will be assigned pseudonyms.

This research project has been designed to make sure the researchers interpret the results in a fair and appropriate way and avoids researchers or participants jumping to conclusions.

There are no costs associated with participating in this research project, nor will you be paid. However, you may be reimbursed for any reasonable travel, parking, meals and other expenses associated with the research project visit.

4 Other relevant information about the research project

In total it is anticipated that 484 people will participate in the research. These may be; Registered Nurses, Enrolled Nurses, People who have attempted suicide, Nurse Educators,

Nurse Unit Managers, Directors of Nursing & Senior Nurse Advisor. Within Monash Health, 2 wards from each hospital at Clayton, Dandenong and Casey will be involved.

All interviews will be conducted using a digital audio recorder enabling transcription of the voice recordings to be undertaken by the researcher.

As a person with lived experience you will be providing input for the project based on your own experiences.

5 Do I have to take part in this research project?

Participation in any research project is voluntary. If you do not wish to take part, you do not have to. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage. If you do decide to take part, you will be given this Participant Information and Consent Form to sign and you will be given a copy to keep.

Your decision whether to take part or not to take part, or to take part and then withdraw, will not affect your ongoing treatment and Nursing care at Monash Health.

6 What are the possible benefits of taking part?

We cannot guarantee or promise that you will receive any benefits from this research; however, possible benefits may include the development and provision of education related to the provision of suicide aftercare.

7 What are the possible risks and disadvantages of taking part?

You may feel that some of the questions we ask are stressful or upsetting. If you do not wish to answer a question, you may skip it and go to the next question, or you may stop immediately. If you become upset or distressed as a result of your participation in the research project, the research team will be able to arrange for counselling or other appropriate support. Any counselling or support will be provided by qualified staff who are not members of the research team. This counselling will be provided free of charge.

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If you do consent to participate, you may withdraw at any time. If you decide to withdraw from the project, please notify a member of the research team before you withdraw. A member of the research team will inform you if there are any special requirements linked to withdrawing. If you do withdraw, you will be asked to complete and sign a 'Withdrawal of Consent' form; this will be provided to you by the research team.

If you decide to leave the research project, the researchers will not collect additional information from you, although information already collected will be retained to ensure that the results of the research project can be measured properly and to comply with law. You should be aware that data collected up to the time you withdraw will form part of the research project results. If you do not want your data to be included, you must tell the researchers when you withdraw from the research project.

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Your information will only be used for the purpose of this research project and it will only be disclosed with your permission, except as required by law. The personal information that the research team collect and use is information obtained from the medical record.

It is anticipated that the results of this research project will be published and/or presented in a variety of forums. In any publication and/or presentation, information will be provided in such a way that you cannot be identified.

In accordance with relevant Australian and/or Victorian privacy and other relevant laws, you have the right to request access to the information about you that is collected and stored by the research team. You also have the right to request that any information with which you disagree be corrected. Please inform the research team member named at the end of this document if you would like to access your information. Any information obtained for the purpose of this research project that can identify you will be treated as confidential and securely stored. It will be disclosed only with your permission, or as required by law.

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Position	Head of School Nursing and Midwifery
Telephone	[redacted]
Email	[redacted]

Name	Dr Kay McCauley
Position	Senior Lecturer
Telephone	[redacted]
Email	[redacted]

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Reviewing HREC approving this project and this research and complaints conatct details

Reviewing HREC name	Monash Health Human Research Ethics Committee B
Name	Ms Malar Thiagarajan
Position	Director, Research Services
Telephone	[redacted]

Appendix 4: Poster presentations

"She's been a naughty girl" – attitudes of nurses in caring for people post suicide attempt

Jakqui Barnfield, Professor Wendy Cross, Dr Kay McCauley
School of Nursing & Midwifery, Monash University

BACKGROUND

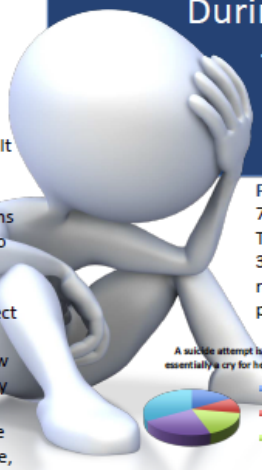
For the first time in ten years, Australia's national reported number of deaths by suicide increased. Data from 2012, showed 2535 people died by suicide (Australian Bureau of Statistics, 2014); that is 6.9 people dying each day in Australia by their own hand and there are estimates that incidents of attempted suicide are 23 times greater than suicides (De Leo, Cerin, Spathonis, & Burgis, 2005). Of these people who attempt suicide and do not die, many require hospitalisation and aftercare; as a result nurses in all subspecialties of practice are likely to provide care for someone at some point in their career who has suicidal ideation or attempted suicide (Lakeman, 2010). Caring for people after they have made a suicide attempt or who have developed suicidal ideation can be a difficult and extremely frustrating experience for nurses (Osborne, 1989; Anderson, 1997; McAllister, Creedy, Moyle, & Farrugia, 2002; Anderson, Standen, & Noon, 2003; Gibb, Beautrais, & Surgenor, 2010; Doyle, Keogh, & Morrissey, 2007). It is not uncommon for nurses to withdraw interaction and care and provide only the necessary functions of the nursing role to someone who has attempted suicide (Simpson, 1998; Osborne, 1989; Bailey, 1994; Main, 1989). It is important to reflect that when nurses engage in avoidance behaviours and withdraw nursing care, it may be perceived by the patient as a form of rejection subsequently increasing their sense of isolation and aloneness (Osborne, 1989; Bailey, 1994; LIFE, 2007).

METHOD

This poster represents the preliminary data for the first phase of a three phase PhD research. This phase will utilize a cross-sectional survey approach to gather data on demographics, defense mechanisms, therapeutic optimism and attitudes to attempted suicide by nurses working in generalist hospital environments.

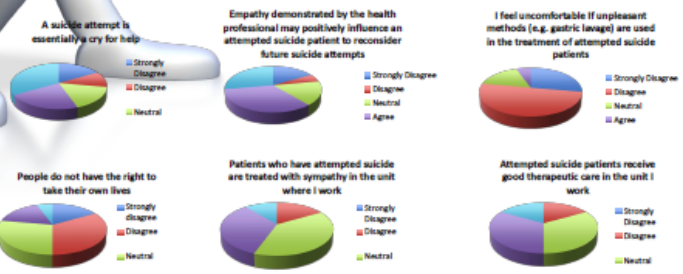
"That's me they're talking about"

Let me tell you about my story. I am an intelligent, articulate, professional woman, but following a suicide attempt my sense of self was taken away. I was admitted to an Emergency Department after I attempted suicide, and was transferred to a Medical Assessment Unit for further medical follow up. During the nursing handover, I heard the ED nurse say, "She's been a naughty girl!".



PRELIMINARY RESULTS

78% of the respondents obtained their nursing qualification in Australia. The respondents range in experience from Graduate nurses to those with 34 years experience. 61% of respondents work fulltime. 83% of respondents report that they could be better prepared to work with people who are admitted to their care following a suicide attempt.



Instruments

Three instruments will inform the cross-sectional survey, with additional demographic data collected to assist with identifying the specific individualities of the participants in order to extrapolate information based on these characteristics.

ELSOM THERAPEUTIC OPTIMISM SCALE (ETOS)

The (ETOS) is a 10 item, 7-point likert type format. Positive optimism correlates to higher scores (highest possible score is 70).

ATTITUDES TO ATTEMPTED SUICIDE-QUESTIONNAIRE (ATAS-Q)

The ATAS-Q has 80 items that assess 8 factors; *positiveness, acceptability, religiosity, professional role and care, manipulation, personality traits, mental illness* and *discrimination*. The questionnaire is a 5 point likert type format. More negative attitudes correlate to low score ratings (lowest score is 80).

DEFENSE STYLE QUESTIONNAIRE (DSQ-88)

The DSQ-88 measures 20 defenses and four defense styles (Cramer, 2006). It assesses across four defense styles; *maladaptive action, self-sacrificing, image-distortion and adaptive* (Ramkissoon, 2014). The questionnaire is a 9 point likert scale.

Suicide anxiety in general hospital

Jakqui Bamfield[1,2], Prof Wendy Cross[1,2], A/ Prof Kay McCauley[3]
[1] Monash Health, [2] Monash University, [3] Massey University

MONASH University

Semi structured interviews were conducted with Nurse Unit Managers (NUMs) of medical / surgical wards where nursing care is provided to people who are admitted following suicide attempts. These were conducted in a large metropolitan hospital in Victoria, Australia. These interviews showed that suicide anxiety is a complex interplay of five constructs.

Stigma

Nurses hold preconceived ideas about how a person will react to the hospital situation following their suicide attempt. Assumptions are made that the person who has attempted suicide did so in order to seek attention. This reinforces the negative perception that people who attempt suicide are not unwell.

Communication

There are two sub themes within the communication construct: avoidance and macabre interest.

Avoidance relates to the lack of engagement the nurses participate in with this cohort of patient. This lack of engagement can be attributed to having to not having intervene if they are unaware of a person's thoughts.

Macabre interest relates to the additional information shared amongst the nursing team during the handover process. This includes not only the mode of attempt, but also in what condition was the person found and who found them.

Capability

The Nurse Unit Managers recognized the lack of knowledge and skills the nurses exhibit when caring for people following suicide attempt. They attributed this to deficits in education and training. Due to these deficits, nurses do not discuss the suicide attempt in case issues are raised in which the nurse is not equipped to deal with.

Of note, is the perception by the NUMs that counseling is an additional aspect to the nursing role, and not one that the generalist nurse should provide.

Suicide Anxiety

is a condition in which an individual acknowledges another's possible death by his or her own hand and experiences emotional reactions that may be subtle or overt.

Risk Concerns

It was apparent that the NUMs and nurses understood the environmental safety issues associated with providing suicide attempt aftercare. Obvious risks were removed, including oxygen tubing and items that were perceived as potential weapons. In order to mitigate against these and potentially other risks, the nurses undertake a review of bed allocations, ensuring these patients are closer to observation points near the nurses station.

There did not appear to be any risk review of the changeable nature of patients' individual risks.

Resource Management

This relates to the above ratio staffing that nurses request. They do this so that there are additional staff available to provide supervisory capacity to these patients. Of note is the resources requested are not limited to more nurses, but also include non clinical staff or third tier workforce.

Nurses work with people who are suicidal or provide suicide attempt aftercare irrespective of the nursing specialty. Subsequently it is essential that nurses recognize suicide anxiety and employ strategies to alleviate the emotions it instills. It is essential that nurses receive the clinical support from their organizations and the opportunity to develop knowledge and skills in caring for this patient cohort. Personal resilience and opportunities for self reflection are important protective factors for nurses.

Appendix 5: Demographic instrument

Information about You - Demographic information

Reference: Modified from McCauley, K. (2004). Midwives and mental health: Survey of Victorian Midwives. Masters thesis. University of Melbourne.

Q1. Where did you gain your professional nursing qualifications?
(Please indicate whether you received this qualification in a hospital or tertiary course by ticking the appropriate box and write the county and year when you received this qualification).

	Hospital training	Tertiary education		Country	Year
		Undergraduate	Postgraduate		
General nursing					
Comprehensive nursing					
	Hospital training	TAFE education		Country	Year
		Certificate IV	Diploma		
Enrolled nursing					

Q2. What other qualifications do you have?

a) ……..
b) ……..
c) ……..
d) ……..

Q3. In which hospital do you work as a nurse?

Hospital 1	☐
Hospital 2	☐
Hospital 3	☐

Q4. What is your work status?

Full-time	☐
Part-time	☐ What are your part time hours per week? ……..
Casual	☐

Q5. Do you have any experience working in a psychiatric nursing setting? YES ☐ NO ☐

(If YES) Please explain

……
…
……
…

If yes, please indicate in time how long your experience was ……. Years / months / days (circle one)

Q6. Have you received education or training in the following topics?

Grief and loss counselling	☐
Interviewing skills	☐
Critical incident debriefing	☐
General counselling skills	☐
Individual therapy	☐
Group work	☐
Alcohol use/abuse	☐
Illicit drug use/abuse	☐
Psychopharmacology	☐
Mental status examination	☐
Suicide risk assessment	☐

Q7. Do you feel you could be better prepared to deal with people who are admitted to your care following a suicide attempt? YES ☐ NO ☐

Q8. What suggestions can you make as to how your education needs about care following attempted suicide could be met?

……
…
……
……
……
……
…

Q9. Please identify the following group which best represents your age**:**

18-29	☐
30-50	☐
51+	☐

Q10. Gender

Female	☐
Male	☐
Intersex	☐

I appreciate your involvement in this research study and would like to thank you for your time and interest

Appendix 6: Elsom Therapeutic Optimism Scale (ETOS)

1. Mental health clinicians have the capacity to positively influence outcomes for people with mental disorders.
2. There is little that can be done to help many people with mental disorders
3. My contribution to positive outcomes is insignificant in comparison to other treatments, for example, medications
4. I can make a positive difference to outcomes for most people with mental disorders
5. Positive outcomes are directly related to the quality of mental health clinician skills and knowledge.
6. There are always new skills and knowledge I can acquire to improve my work.
7. The outcome of mental disorders is not significantly affected by clinician interventions.
8. With my assistance most people with mental disorders will recover.
9. Often there is little I can do to help people with their mental illness.
10. Even the most challenging clients can benefit from my intervention.

Appendix 7: Attitudes to Attempted Suicide Questionnaire (ATAS-Q)

1. I would feel ashamed if a member of my family attempted suicide
2. People who attempt suicide are irresponsible
3. Once a person attempts suicide, he is suicidal forever
4. A suicide attempt is essentially a cry for help
5. Attempted suicide, such as an overdose of sleeping pills, is more acceptable than violent suicide such as by gunshot
6. People who attempt suicide have sensibilities that are not detectable by others around them
7. Those who attempt suicide are cowards who cannot face life's challenges
8. People who attempted suicide occupy more staff time so staff are unavailable to patients who are "in greater need of help"
9. Empathy demonstrated by the health professional may positively influence an attempted suicide patient to reconsider future suicide attempts
10. The majority of people who attempt suicide misuse health care services
11. Whenever I care for attempted suicide patients I feel uncomfortable
12. If unpleasant methods (e.g. gastric lavage) are used in the treatment of attempted suicide patients they can prevent the patient from attempting suicide again
13. Sometime I fell nervous when I have to care for an attempted suicide patient in hospital .
14. A person who has made numerous suicide attempts is at high risk of succeeding in the future and needs help and understanding

15. I am happy to care for attempted suicide patients and I feel the same sympathy as I care for other patients
16. It is frustrating to treat patients who have attempted suicide
17. I have difficulties in understanding a person who attempted suicide
18. I like to help patients who have attempted suicide
19. I try to establish communication with an attempted suicide patient so he may express the problems he encounters
20. I often feel sympathy and understanding towards attempted suicide patients
21. Hospitalized attempted suicide patients will make future suicide attempts, regardless of how supportive health care professionals were to them
22. I believe that hospitalized, attempted suicide patients will be unable to have a normal life following their discharge
23. It is difficult and unpleasant to treat an attempted suicide patient
24. Attempted suicide patients think only of themselves
25. Attempted suicide patients must be treated using “strict” methods
26. Attempted suicides are not responsible for their actions but are victims of their environment and they need understanding
27. The fact that a person attempted suicide it doesn’t mean that the normal course of their life tipped over
28. People with incurable diseases should be allowed to commit suicide in a dignified manner .
29. People who attempt suicide have a high level of responsibility
30. Attempt suicide is acceptable for old or infirm people
31. Suicide is an acceptable means to end an incurable illness
32. There may be situations where the only reasonable resolution is suicide

33. External factors, like lack of money, are a major reason for suicide
34. Sometime suicide is the only escape from life's problems
35. If someone wants to commit suicide, it is their business and we should not interfere
36. People who die by suicide should not be buried in the same cemetery as those who die naturally
37. Potentially, every one of us can attempt to suicide
38. People do not have the right to take their own lives
39. A suicide attempt is a brave act
40. An attempt to suicide is an acceptable act in specific cases.
41. The higher incidence of suicide is due to the lesser influence of religion
42. In general, suicide is a sin not to be condoned
43. Suicide is a very serious moral transgression
44. Suicide goes against the laws of God
45. People who commit suicide lack religious convictions
46. Most people who attempt suicide do not believe in God
47. People who attempt suicide are, as a group, less religious
48. Suicide is a natural way of obliterating people with psychiatric problems .
49. Patients in the place/unit I work receive good care
50. I believe that the training I have completed to date, has given me adequate skills to care for patient who have attempted to commit suicide
51. In the place I work there is considerable number of employees who have indifferent attitude towards their work
52. I think there is esprit de corps in the unit I work
53. Patients who have attempted suicide are treated with sympathy in the unit

where I work

54. Attempted suicide patients receive a good therapeutic care in the unit where I work
55. An attempted suicide patient benefits psychologically by his hospitalization in a general hospital
56. Some attempted suicide patients are aggressive and there is a need for security staff in the unit of the hospital to which they are admitted
57. When I care for attempted suicide patients, I feel depressed
58. People who attempt suicide are in essence trying to hurt somebody with their actions
59. Attempted suicide patients mainly try to manipulate their situation to their advantage
60. Suicide attempters who use public places (such as bridge or tall buildings) are more interested in getting attention
61. Those people who attempt suicide are usually trying to get sympathy from others
62. People who bungle suicide attempts really did not intend to die in the first place
63. People who attempt suicide hope to achieve something other than death
64. Most people who attempt suicide are lonely and depressed
65. Most people who attempt suicide don't really want to die
66. Those who threaten to commit suicide rarely do so
67. People with no roots or family ties are more likely to attempt suicide
68. Many attempts to suicide are the result of the desire of the victims to "get even" with someone

69. It is rare for someone who is thinking about suicide to be dissuaded by a "friendly ear"
70. People who attempt suicide are usually mentally ill
71. People who attempt suicide and live should be required to undertake therapy to understand their inner motivation
72. Attempted suicide patients must be treated on a psychiatric ward of a general hospital on the day their admission
73. People who attempt suicide are so mentally ill that they should be treated in psychiatric hospitals from the outset
74. People who attempted suicide must be treated by community services
75. I think I need additional psychiatric training in order to care for the hospitalised attempted suicide patients
76. Almost everyone has at one time or another thought about suicide
77. We care for all attempted suicide patients in the same room/ ward on the unit in which I work
78. I feel more sympathy towards a person who attempted suicide for the first time than for those who make repeated suicidal attempts
79. Only health care professionals with psychiatric training should take care of attempted suicide patients
80. We should have separate rooms in hospitals for the care of attempted suicide patients

Appendix 8: Defense Style Questionnaire (DSQ-88)

1. I get satisfaction from helping others and if this were taken away from me I would get depressed.
2. People often call me a sulker.
3. I'm able to keep a problem out of my mind until I have time to deal with it.
4. I'm always treated unfairly.
5. I work out my anxiety through doing something constructive and creative like painting or woodwork
6. Once in a while I put off until tomorrow what I ought to do today.
7. I keep getting into the same type of frustrating situations and I don't know why
8. I'm able to laugh at myself pretty easily.
9. I act like a child when I'm frustrated.
10. I'm very shy about standing up for my rights with people.
11. I am superior to most people I know.
12. People tend to mistreat me.
13. If someone mugged me and stole my money, I'd rather he'd be helped than punished.
14. Once in a while I think of things too bad to talk about.
15. Once in a while I laugh at a dirty joke.
16. People say I'm like an ostrich with my head buried in the sand. In other words, I tend to ignore unpleasant facts as if they didn't exist.
17. I stop myself from going all out in a competition.
18. I often feel superior to people I'm with.

19. Someone is robbing me emotionally of all I've got.
20. I get angry some times.
21. I often am driven to act impulsively.
22. I'd rather starve than be forced to eat.
23. I ignore danger as if I were Superman.
24. I pride myself on my ability to cut people
25. People tell me I have a persecution complex.
26. Sometimes when I am not feeling well I am cross.
27. I often act impulsively when something is bothering me.
28. I get physically ill when things aren't going well for me.
29. I'm a very inhibited person.
30. I'm a real put-down artist.
31. I do not always tell the truth.
32. I withdraw from people when I feel hurt.
33. I often push myself so far that other people have to set limits for me
34. My friends see me as a clown.
35. I withdraw when I'm angry.
36. I tend to be on my guard with people who turn out to be more friendly than I would have suspected.
37. I've got special talents that allow me to go through life with no problems.
38. Sometimes at elections I vote for someone about whom I know very little.
39. I'm often late for appointments.
40. I work more things out in my daydreams than in my real life.
41. I'm very shy about approaching people.
42. I fear nothing.

43. Sometimes I think I'm an angel and other times think I'm a devil.
44. I would rather win than lose in a game.
45. I get very sarcastic when I'm angry.
46. I get openly aggressive when I feel hurt.
47. I believe in turning the other cheek when someone hurts me.
48. I do not read every editorial in the newspaper every day
49. I withdraw when I'm sad.
50. I'm shy about sex.
51. I always feel that someone I know is like a guardian angel.
52. My philosophy is, "Hear no evil, do no evil, see no evil"
53. As far as I'm concerned, people are either good or bad.
54. If my boss bugged me, I might make a mistake in my work or work more slowly so as to get back at him.
55. Everyone is against me.
56. I try to be nice to people I don't like.
57. I would be very nervous is an airplane in which I was flying lost an engine.
58. There is someone I know who can do anything and who is absolutely fair and just.
59. I can keep the lid on my feelings if it would interfere with what I'm doing if I were to let them out.
60. Some people are plotting to kill me.
61. I'm usually able to see the funny side of an otherwise painful predicament.
62. I get a headache when I have to do something I don't like.
63. I often find myself being very nice to people who by all rights I should be

angry at.

64. There's no such thing as "finding" a little good in everyone". If you're bad, you're all bad.
65. We should never get angry at people we don't like.
66. I am sure I get a raw deal from life.
67. I fall apart under stress.
68. When I know that I will have to face a difficult situation, like an exam or a job interview, I try to imagine what it will be like and plan ways to cope with it.
69. Doctors never really understand what is wrong with me.
70. When someone close to me dies, I don't feel upset.
71. After I fight for my rights, I tend to apologize for my assertiveness.
72. Most of what happens to me is not my responsibility.
73. When I'm depressed or anxious, eating makes me feel better.
74. Hard work makes me feel better
75. My doctors are not able to help me really get over my problems.
76. I'm often told that I don't show my feelings.
77. I believe that people usually see more meaning in films, plays or books than is actually there.
78. I have habits or rituals which I feel compelled to do or else something terrible will happen.
79. I take drugs, medicine or alcohol when I'm tense.
80. When I feel bad, I try to be with someone.
81. If I can predict that I'm going to be sad ahead of time, I can cope better.
82. No matter how much I complain, I never get a satisfactory response.
83. Often I find that I don't feel anything when the situation would seem to

warrant emotions.

84. Sticking to the task at hand keeps me from feeling depressed or anxious.
85. I smoke when I'm nervous.
86. If I were in a crisis, I would seek out another person who had the same problem.
87. I cannot be blamed for what I do wrong.
88. If I have an aggressive thought, I feel the need to do something to compensate for it.