

The borderline between life and death: Mental healthcare professionals' experience of why patients commit suicide during ongoing care

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Abstract

Aims and objectives

To explore mental health professionals' experiences in regard to circumstances that cause the patient to take their own life during ongoing care.

Background

Suicide is a worldwide health problem, and of those who take their own life, nearly 20% have had contact with a psychiatric unit. Mental health professionals may have extended intuitive knowledge that has not been made visible. Mental health professionals' experiences can contribute knowledge that can complement suicide risk assessments and can be helpful in developing approaches and strategies where the hope is to identify and draw attention to people at risk of taking their own life.

Design

A reflective lifeworld research.

Methods

Twelve interviews with mental health professionals with experience of working in caring relationships with patients that had taken their life during the period of care. The study was performed in accordance with COREQ (see Supporting Information Data S1).

Results

Mental health professionals' experiences regarding circumstances that cause the patient to take their own life are related to the patient's life circumstances that led to a loss of dignity, and finally beyond retrieval. Mental health professionals share patients' struggle to choose between life and death, the darkness of their life and their hopeless situation. This shared experience also makes the mental health professionals wish to relieve patient's suffering but also gives them an understanding of why patients take their own life.

Conclusions

The mental health professionals experience how the patient loses the possibility of living a worthwhile life, recognise darkness within the patient and see how the patient's life is fragile. Suicide described as logical and expected, based on their life and life circumstances, has not been found in previous research. Bearing this in mind, should psychiatric care focus on a proactive approach and act when these circumstances are identified?

Relevance to clinical practice

The Mental health professionals' tacit knowledge may be used to strengthen uncertain suicide assessments.

What does this paper contribute to the wider global clinical community?

- Tacit knowledge, acquired by experience, which healthcare professionals possess, can probably play a larger role in suicide risk assessments than currently.
- A consciousness of the healthcare professional's reactions to the patient's suffering can add value to present standards of suicide risk assessments.
- The circumstances surrounding a patient's suicide, from the perspective of healthcare professionals, have rarely been described in previous research.

1 INTRODUCTION

Suicide is a worldwide health problem and is among the 20 top causes of death in the world. About 800,000 people commit suicide each year, of which about 1,500 people are in Sweden (World Health Organization, [2017](#)). In addition to those who commit suicide, there are many more that make suicide attempts. Thus, millions of people suffer each year themselves or know someone who took their own life. Of those who take their own life, nearly 20% have ongoing or previous contact with a psychiatric unit (Lonnqvist, [2009](#)), and among suicide decedents, 80% had a past-year contact with the primary healthcare service (Stene-Larsen & Reneflot, [2017](#)). Therefore, mental health professionals (MHPs) have the opportunity to identify early signs and prevent suicidal behaviour (Bolster, Holliday, Oneal, & Shaw, [2015](#)). By highlighting their experiences, this paper will extend the knowledge about life circumstances that precede suicide.

1.1 Background

Suicide occurs at all ages and is the second most common cause of death among 15- to 29-year-olds (World Health Organization, [2018](#)) (WHO). Although suicide is a major problem, it has gained relatively little empirical attention (Van Orden et al., [2010](#)). Increased interest in suicide research has resulted in a greater understanding of suicide risk factors (Nock et al., [2009](#)). There is a certain difference between risk factors and warning signs that may lead to suicide (Rudd et al., [2006](#)).

Known risk factors, such as mental illness or a history of suicide attempts, are not enough to assess suicide risk. Intensified suicide risk is often short-term and situation-specific, why a patient's history of suicide attempts, together with current suicide tendency, can result in a better assessment (World Health Organization, [2018](#)). A variety of clinical factors in the literature have explained different warning signs for suicide attempts. The patient can describe a lack of reasons for continuing to live, feeling hopeless and may show withdrawal from friends and family. Other signs may be increased drug use or the patient acting negligently or participating in risky activities (American Association of Suicidology, [2016](#)). Although it is an important task for MHPs to be able to identify patients with an increased risk to take their own life, the behaviour is complex and difficult to predict, and not all MHPs are properly educated and trained in suicide assessment (Bolster et al., [2015](#)). Researchers have therefore developed interview and assessment tools to facilitate and improve clinical assessment. There are several measuring instruments for detecting suicide risk, but there is no scientific evidence that the instruments have sufficient accuracy to predict future suicide and it is not clear whether these instruments can contribute to the clinical assessment (Runesson et al., [2017](#)). Runesson et al. ([2017](#)) further state that the instruments can serve as educational support for less experienced healthcare professionals. It is thus unclear whether it is possible for healthcare professionals to prevent suicide by using these instruments.

If MHPs rely on instruments rather than listening to the patient, it can negatively affect health care. Often contact with staff is perceived as monitoring and objectifying (Talseth, Gilje, & Norberg, [2003](#)), and there are descriptions of how suicidal patients experience nursing care as emphasising protective practice consisting of close observation and preventing the person from harm herself/himself (Cutcliff & Stevenson, [2008](#)). This practice is in contrast to research that emphasises a more care-oriented approach where the patient wants to be given time and be listened to without judgment (Vatne & Nåden, [2014](#)). Suicidal patients suffer from (Berglund, Åström, & Lindgren, [2016](#)) and have difficulties dealing with emotions such

as despair, alienation, shame and self-loathing (Everall, Bostik, & Paulson, 2006) and want these emotions to be seen and understood by the MHPs (Cutcliffe & Stevenson, 2008). Previous studies show that MHPs' ability to pick up suicidal cues seems to be an emotional and experience-based competence that may prevent suicidal acts among patients (Hagen, Knizek, & Hjelmeland, 2017). MHPs seem to observe both verbal and nonverbal communication as expressed by the patients. This ability is described as intuition in experienced MHPs' suicide assessments (Aflague & Ferszt, 2010; Tofthagen, Talseth, & Fagerström, 2014). The opposite is found among nursing students who do not interact with suicidal patients on a regular basis. They have expressed lack of competence in caring for persons showing suicidal behaviour (Scheckel & Nelson, 2014). Experienced nurses develop skills and understanding of patient care over time through a sound educational base and expand their experience of interacting with patients (Benner, 2001). However, suicide is found to evoke painful feelings in the professionals, and caring for suicidal patients is one of their most challenging tasks (Hagen et al., 2017). World Health Organization (2017) works to increase the awareness of suicide and to make suicide prevention a high priority on the global public health agenda. Still, only a few countries have included suicide prevention among their health priorities, and only 28 countries report having a national suicide prevention strategy. So, even today, little is known about how to make proper suicide risk assessments (Runesson et al., 2017). MHPs with extensive experience can have expert knowledge, which is intuitive (Benner, 2001). In addition, they often form a caring relationship with the patient during the patient's time in psychiatric care. Therefore, their experience of psychiatric care and the caring relationship that preceded a suicide is important and can contribute knowledge that can lead to new ways of understanding suicide risk assessments. The knowledge can be helpful in developing approaches and strategies for MHPs, patients and relatives where the hope is to identify and draw attention to people at risk of suicide.

1.2 Aim

To explore mental health professionals' experiences of circumstances that causes the patient to take their own life during ongoing care.

2 METHODS

2.1 Design

To grasp the everyday understanding of mental health professionals' experience of why patients take their own life, a phenomenological lifeworld perspective was chosen (Dahlberg, Dahlberg, & Nyström, 2008). This phenomenological approach is grounded in the lifeworld as the starting point. This turns the research towards the MHP's lifeworld, which is a relational world, full of meaning. It is neither an objective world nor a subjective, but only a world to consciousness (Todres, Galvin, & Dahlberg, 2007). This approach highlights the MHP's silent, tacit knowledge that often is taken for granted. The research process and how the method and result are compiled have followed the COREQ guidelines (Tong, Sainsbury, & Craig, 2007; see Supporting Information Data S1).

2.2 Data collection

Inclusion criteria were as follows: MHPs, with at least 2 years of professional experience in psychiatric care and with experience of working in caring relationships with patients that had

taken their own life during the period of care within the last 3 years. Healthcare managers were used to find personnel with that particular experience. The sample was purposeful (Patton, 2015) and consisted of 12 informants who worked in three different regions with varying backgrounds (see Table 1) which would reduce the risk of describing MHPs experiences of a particular local healthcare culture, which Patton (2015) refers to as representativeness.

Table 1. Characteristics of the study population

Profession	Total 12
Psychiatric nurse	8
Assistant nurse	4
Gender	
Female	5
Years of experience	2–32 (14 _a)
Place of work	
Forensic psychiatry	4
Psychiatric outpatient care	4
Psychiatric inpatient care	4

- ^a Values are median (range).

The interviews took place in late 2016 and early 2017. The informants were given the choice of time and place for the interview, which were conducted at both the different clinics and in the university premises in rooms with little chance of being interrupted. Before the interview started, informants received information about the project and a reminder that participation was voluntary. There was also time for questions and for a general conversation to create a safe and relaxed atmosphere. The interviews focused on the question: Can you share your experiences of caring for a patient who took her/his own life during the period of care? In order to gain clarification or to get in-depth answers, probing questions (Dahlberg et al., 2008) such as “Can you tell me more?” were asked. Four interviews were conducted by each author, who were all experienced in qualitative interviewing technique.

The interviews lasted between 38–92 min, with an average length of 63 min. After the interview, there was time for continued reflection between informants and interviewers based on the idea that nobody would leave the room before feeling ready for it.

2.3 Analysis

The interviews were audio-recorded and transcribed verbatim. Data were analysed following the reflective lifeworld research (Dahlberg et al., 2008). In both the interviews and in the analysis, the phenomena were explored without theoretical interpretations and constructions. The transcripts were first read several times separately in order to get to know the text. The text was later divided into meaning units. The meaning units were discussed and grouped into clusters. The researchers then separately read the text to get a sense of the essential meanings and structures. A continuous discussion was held of the texts and how the clustered meanings were related to each other in order to discover a new whole. The process was guided by questions such as the following: How do they experience the suicide? How do they explain why the patients take their own life? Is there a difference between suicide that comes as a

surprise or suicide that is more expected? How does the experience of the suicide relate to the lifeworld constituents (Todres et al., 2007). The goal was to find a general structure that illuminated the essence and its constituents. The essence of the experience of why patients take their own life is the phenomenon's invariant meaning, what it is. The constituents describe nuances and variations of the individual's experience of why the patients commit suicide. Through the whole process which led to the general structure, the research group asked each other critical questions to facilitate a "bridling" attitude (Dahlberg, 2006). This means to restrain the preunderstanding and not let personal beliefs or theories bias the analysis. It also means that the understanding is allowed to linger and not too quickly evolve. In preparing and carrying out the interviews, the research team questioned each other's understanding and the underlying preunderstanding in how we asked interview questions and follow-up questions. To avoid quick decisions of what the text says, during the text analysis, we met as a team every 2 months during a whole year where the essence and its constituents were questioned and developed. We were especially aware of interview text we immediately did not understand or surprised us, since this was text that challenged our preunderstanding.

2.4 Ethical consideration

Plenty of time was reserved for the interviews. In the interviews, it was explained that the aim was not to search for personal faults but instead to understand the subjects' experiences. As the research area is of such a nature that it may raise feelings which are difficult to handle, a psychologist was available if the interviewed staff experienced a need for further support. This support was not used. Principles of written informed consent were followed. Before the interviews, the informants received oral and written information that participation was voluntary and that they could withdraw from the study without any explanation. The study was performed in accordance with the Declaration of Helsinki (World Medical Association Declaration of Helsinki, 2017) and approved by the Regional Ethical Review Board in Linköping, Sweden (Dnr 2016/343-31). The reader of the results section must bear in mind that what caused the suicide is exclusively ascertained in the MHPs perceptions and beliefs.

3 RESULTS

The results first present the essence of mental health professionals' experiences about circumstances that cause the patient to take their own life. The constituents, the meanings that constitute the actual essence, follow this.

3.1 Essence description

The essence of mental health professionals' experiences about circumstances that caused the patient to take their own life during ongoing care related to the patient's life circumstances that led to their loss of dignity and a growing insight that there was no possibility of retrieval. The patient's life was described by the MHPs as meaningless, empty and hopeless. This condition was described as the patient being in a state of darkness, a darkness that often was silent and wordless. The darkness in life surrounded the patient and tempted the patient to commit suicide as the only solution to banish the darkness. This darkness was also shared by the MHPs as a physical experience within their own bodies. The MHPs expressed a struggle between helping and creating a light in the dark while there was at the same time an understanding that the patient took their own life based on a darkness in life resulting from a life without purpose. The suicide could cause a sense of a personal or organisational failure,

but MHPs also experienced the suicide as a relief from an unbearable suffering. In this experience of the patient's life darkness, MHPs described ambivalence and a borderline between life and death where small life changes could cause the patient to give up their struggle. Deficiencies in the care and care organisation may be what tip the patient over to take their own life.

3.2 Losing the possibility of a worthwhile life

Mental health professionals identify that the suicide was related to that the patient has lost something and that patients' life no longer is predicted to be able to live as before. The loss was related to what the patient previously perceived as important but which could no longer be realised, with the result that everyday life became meaningless. The MHPs understood this life as unworthy. For example, a disease insight in a psychotic disorder involves an awareness that the disease has taken something from the patient. In the quotation below, one of the nurses speaks with a patient's voice:

it was always 'I wanted an education, I want family and a girlfriend and it's not possible. Now I've been ill for a long time and I'm not getting better and I'm getting sick because of the medicines and I do not want to take this medicine. I get impotent, I cannot even try with girls. I will be like this forever.'

Earlier living opportunities and talents that the person possessed are lost when mental health deteriorates. The disease can thereby create a lack of freedom to do what they want with their lives, which is sometimes described as a reason for the patient to choose to commit suicide. The personnel also described how a sense of loss could arise from the fact that the psychiatric care, such as forensic psychiatric care, prevents the patient from living the life the patient wants, as illustrated in the following quote:

..to do what he wants to do, not leave urine sample the whole time. You know, to live his life, destructively or not... be in his apartment and use drugs

The personnel also said that the loss of various persons and a lonely life could be seen as explanations for the patients to take their own life. They understood the patient's life as unworthy, a life of nothing:

At the funeral were the mother and me, a priest and a verger. And also a cantor. And on the top of the coffin there were two bouquets, one from the mother and one from us at the hospital. Goodness, it was terrible. It was so obvious that he had nothing

The loss can be directly linked to a divorce or to becoming unemployed; however, the loss can also be described as being unable to have children or being forced into loneliness based on the life difficulties caused by the disease. The loss of others creates a loneliness that is sometimes directly linked to different life events, while others have lived with these circumstances their whole life.

The MHPs also described how the dignity of the patient was compromised and experienced as lost due to psychiatric health care. It often related to the medications the patient was treated with and the side effects of these. The drugs had in many ways destroyed the patient's lives. One patient was a skilled artist before he received his diagnosis, but he had lost that talent partly due to the medication:

In this trauma, his life went downwards. He was hospitalized and received various treatments and he didn't think they were the right treatments. He got a lot of medications. He said something like 'These medications... these side effects have fucked up my head'

3.3 A darkness impossible to live with

The MHPs experienced that the patient's suicide was directly related to the patient having a life situation that was hopeless and described as darkness that was impossible to live with. Sometimes the darkness could express itself as things that could not be undone, divorce or pain, but the darkness was visible and noticeable in contact with the patient. In this darkness, there was an emptiness and a hopeless feeling that "life is not worth anything." After the suicide, the MHPs could understand that the patient gave up in the belief that their life was over:

He was in a darkness that always had a hold of him and never fully left him

The darkness permeated the entire life of the patient and had characterised the patient's life for a long period of time. The MHPs experienced being unable to reach the patient and found this darkness could not be dispelled:

It was both frustrating and, well, sad. You could never really reach him, it was like... You became very empty.... Yourself

The MHPs tried to reach the patient without success. It led to a sense of emptiness described as a physical feeling within the MHPs. They experienced that their own feelings when providing care could reflect the darkness of the patient. These were emotions that remained with the MHPs for a long time and emotions that they could experience when they met other patients with the same darkness:

I had horrible feelings and didn't know how to handle them... I felt so bad, even today I feel bad

Sometimes the darkness of the patient was related to things that could not be undone. It may be about being a victim of abuse or going through a divorce. The patient had to live with what had happened and had difficulties coping and was often reminded of the challenges. Sometimes the darkness was related to the overall patient's life situation and childhood. In several interviews, the darkness was related to the patient's experience of physical pain. It was a pain that the patient had been living with for a long time without the possibility of improvement:

He lived with a constant blackness and the suffering from the pain must have been enormously heavy to bear

The pain was difficult to relieve and sometimes difficult to understand for the MHPs. The patient's darkness was also related to suffering from somatic diseases and being of old age and how this meant being dependent on help from others.

The patient had been struggling in the darkness for a long time and eventually they gave up the fight. This created a frustration within the MHPs as they experienced they were not able to help. They described it by saying the help was "bouncing back." The fact that the darkness

was difficult to disperse may also be due to the difficulty of describing it. One nurse spoke about a patient that referred to a song text by Eminem; “Cleaning out my closet.” It was a text that the nurse could understand was related to how the patient experienced her life. In retrospect, when she reflected on the lyrics, she felt that the patient thought this song conveyed something about her life and darkness.

The interviews show that the darkness was so extensive that the MHPs said that they could understand why the patient committed suicide:

If I had been her and as a child found my mother dead in a car full of gas... if I had been placed into foster care... have recurrent delusions and feel as badly as she did for 25 years... I don't think I would have been as strong as she was

The MHPs thus seemed to experience the suicide as a logical consequence of an eternal darkness.

3.4 When life is fragile

The MHPs experienced that the patient before the suicide had lived life with death as a close and possible way out, when life is fragile. They said that single small events or changes could cause this thread to break, for example, a treatment failure, being discharged from hospital or organisational changes. It appeared that it could be difficult for patients when they deteriorated and took a step back in their development. The MHPs experienced that persons who take their own life often been at some kind of crossroads in life that MHPs interpreted as impossible to handle. When life is fragile for the patients was manifested in the stories of the MHPs through the feeling that the patients became very sensitive to changes related to discharge from the hospital, both short and long hospital stays. The stories revealed how the MHPs often looked bleakly at the patient's odds when he or she moved back to the community. After many years in psychiatric care, one MHP described this regarding a patient that no longer seemed able to live outside the hospital:

One patient had been here for 14 years... and he was scared to death of the outside life. He was supposed to get an apartment... that was OK for one and a half days. He climbed the walls and was terrified. He said it was so tough outside... What kind of life did he have, really? He was so institutionalized... and then he was discharged... You wonder what you discharged them to. It is a failure. We know that before they have left the hospital

The MHPs found that some suicides could be described as accidents related to the fact that the patient's life is fragile for a long period of time, with repeated self-harm or suicide attempts. The suicide could be explained as a failed self-harm behaviour:

It was, as she described it, not a genuine suicide wish. Instead, it was more to get rid of this increase in anxiety, a possibility to start afresh from square one. She belonged to the group of persons when you suspect the suicide to be an accident

There are also suicides where MHPs believe that the patient did not intend to take their life but instead experienced an impulse response in reaction to a psychotic experience. This may also mean that a person taking extra medication for anti-anxiety purposes can acquire toxic levels which the body cannot cope with, leading to death. When life is fragile, the MHPs do not feel that suicide is always intentional.

When the patients' life is fragile, the patient's suicide can also be related to the care organisation. There may be insufficient continuity; for example, contact persons may be changed in reorganisations or the organisation may relocate and leave patients alone with their thoughts. The MHPs also described how reorganisation can lead to a "vacuum" in the healthcare organisation where no one takes responsibility for the patient. They also described "anorectic organisations" where care contacts are short and lacking continuity.

Since the patient life already is fragile, the MHPs experienced that these care organisational changes meant that MHPs deceived the patient, which can be an important reason why the patient "tips over" and take their own life. The narratives also reveal several other explanations for the patient's suicide based on the fact that life is fragile. One patient was denied disability compensation by society, despite an obvious disability, and another patient was moved from his residence to an accommodation with a higher psychiatric care level, against his will:

He just said: I don't want to move, I am not going to move to that place and then he became very upset. And perhaps it happened sometimes that he said 'I'd rather die than move there', but we never thought of this as a suicide threat

3.5 Death as a relief

It was found that suicide can be interpreted as a relief for the patient. In some cases, the MHPs felt that patients had finally gained peace from what they considered a worthless life. This means that MHPs saw the suicide not only as something tragic and unexpected but also as something understandable and expected. They expressed an understanding of what had happened based on tragic life experiences filled with anxiety and depression:

She was build of anxiety cells so the days or hours she didn't have anxiety were a bonus, so to speak... she was like a trembling young bird. She felt so bad and had felt that way her whole life... she had no hope and was so characterized of her disorder. There were not many health factors in her surrounding... I can understand why she took her life

Another reason why the suicide can be seen as a relief is illustrated in the narratives as patients lived with horrible memories that they had not managed to reconcile. The lives of some patients were perceived as completely meaningless and without hope, which made suicide a way out of a hopeless situation. Some of the patients perceived their lives as worthless and so characteristic of struggle that it is expressed as not worthy to live:

I can understand why he took his life. And especially when there was a crime involved. You know, this guy, he felt so bad and had anxiety about what he had done to the relatives. It is wretched human destiny. I think he could never forgive himself for what he had done. And I can understand that... that he took his life, because I was not surprised. And... He found peace. I think he has it better now because worse is not possible

The MHPs also disclosed that relatives sometimes shared their experiences of the suicide as a relief. Although close relatives expressed sadness, there was also an understanding of what had happened. Among other things, it was said that close relatives expressed feelings of relief and that the suicide meant that the person had finally found peace:

Of course, she (the wife) was sad. She was in despair but at the same time... there was a relief. Later, her son called me, they thought it was better for dad now and that he had finally found peace

The fact that the patients, because of their mental health problems, did not always have the same opportunity to live a life like others was described in the narratives. The MHPs sometimes describe the patients' lives as "tragic" and "boring." Sometimes the patients did not seem to be better, but rather, there were descriptions of how young fresh people over the years became more and more characterised by their illness, both functionally and also in appearance. In the light of this, they wondered why more people did not choose to commit suicide:

It is strange that there are not more people with mental illness who take their lives... The first relapse... I mean, these girls are fresh-looking with fast recovery, they are young, thin and have a social network, manage school, have family... Then comes next relapse and the next... and they slowly lose functions that make them unable to perform as before. They are aware that the disease slowly eats away at their abilities...

The MHPs experienced that the patient could not live the life that he/she had previously lived. They therefore did what they could to bring hope to the patients' dark future vision by telling stories about people living a good life despite mental illness. Regarding the patients total situation, MHPs described the suicide as a reasonable choice:

Life does not conform to the standards you have for your life and then I think, and I can understand why you do it. Yes I can understand the feeling and I can understand that you choose to end your life

4 DISCUSSION

Mental health professionals' experiences of the circumstances that cause the patient to take their own life during ongoing care are related to the patient's life circumstances that led to a loss of dignity, with no possibility of retrieval. They experience and share the patient's struggle between life and death, their darkness in life and their hopeless situation. This shared experience also makes the MHPs wish to relieve a patient's suffering but also gives an understanding of why they took their life.

What makes this study unique is that it explores MHPs' experiences of circumstances around a patient's suicide, which has been given little attention in scientific literature. Previous research has mainly focused on experience of caring for suicidal patients in psychiatric care (Bohan & Doyle, 2008; Hagen et al., 2017) and experiences of inpatients' suicide in general hospitals (Matandela & Matlakala, 2016). However, the studies do not concern MHPs' reflections on suicide. Suicidal actions may appear acute but often are the result of a long-term suicidal process that lasts for several months, sometimes a lifetime (Beskow, 2000). MHPs have the prerequisites to develop an understanding of the patient's situation and suffering (Butts & Rich, 2011). Thus, their experiences need to be highlighted for increased understanding of why the patients take their own life.

The results show that patients who take their own life have often lost their dignity and are not able to do what they expect to do with their lives. Lost dignity may be related to the concept of self-burden, the factor that is most strongly related to suicide (Ma, Batterham, Calcar, &

Han, 2015). Another component that weighs heavily is whether the person has lost hope (Anestis, Moberg, & Arnau, 2014) which is also illustrated in this study's constituent as "losing the possibility of a worthwhile life." Thus, these results are in accordance with previous research.

Another finding is patients' loss of dignity with no possibility of retrieval. This can create feelings of guilt, shame or abandonment and prevent the person from talking about suicidal thoughts or seeking treatment (Pompili, 2010; Pompili, Mancinelli, & Tatarelli, 2003). This in turn exposes them to a greater risk of suicide, but also makes suicide appear as the best solution for the person. It is important to bear in mind that the patients' perceptions of dignity are associated with both clinically and culturally competent care, suggesting nurses must not only understand their patients from the standpoint of symptoms, diagnosis and treatment, but should also understand the context of their experiences and culture (Asmaningrum & Tsai, 2017). Thus, MHPs need to strive to understand the reasons for as well as the meanings and functions of the suicidal wish in order to make and implement healthcare plans to meet the needs of individual patients (Rodríguez-Prat, Balaguer, Booth, & Monforte-Royo, 2017).

When the healthcare professionals recognise that the patient has lost dignity in life they relate this to suffering (Eriksson, 2007), which patients can physically feel, and metaphorically describe this as the patient's darkness. This unbearable suffering is a darkness in life, a slow dying away where the person is alienated from himself (Rehnsfeldt & Eriksson, 2004). Suicide could therefore be conceptualised as a statement of unbearable suffering, where the suicide is an escape (Long, Long, & Smyth, 1998). Suicide understood as caused by an unbearable suffering means that nurses should focus on the patient's experience as a complement to the diagnostic framework. If awareness was increased about the fact that the patient's darkness and life are reflected in the feelings of the MHPs, this could be a valuable complement to suicidal assessments. It does not mean that the diagnoses or measuring instruments are unimportant, but MHPs need to reach out and try to understand the suicide patient's suffering (Berglund et al., 2016) and emotions (Vatne & Nåden, 2014), as well as their own feelings. MHPs try to formulate words for this unarticulated darkness, in order to create a language of the person's experience (Vatne & Nåden, 2014). Recovery experienced by persons at risk of taking their own life is described as reconnecting with oneself in a struggle between life and death (Sellin, Asp, Wallsten, & Wiklund, 2016). The MHPs in our study described patients as being in a state where the struggle was over and a reconnection with oneself was experienced as impossible. The person gave up and accepted the fact that life was not worth living, and as the results show, this was not first and foremost a sadness but a relief.

This study identified how the MHPs recognised how the patients' life is fragile where small things could make the patient choose between life and death. This experience of the MHPs is in line with previous research stating that suicide rarely occurs without a struggle (Lakeman & FitzGerald, 2008) and that the emotional pain and hopelessness moves back and forth between suffering and enduring (Morse & Penrod, 1999). It is therefore important that MHPs recognise the struggle and are open and sensitive to the patient's lifeworld as both dark and light, as a health obstacle and a health resource (Sellin et al., 2016). An unexpected finding is that suicide appeared as logical and expected by the MHPs, based on the life and life circumstances of the person concerned. As far as we know, this has not been found in previous research. Bearing this in mind, should psychiatric care focus on a proactive approach and act when these circumstances are identified? The finding that MHPs also experienced the suicide as a relief needs to be discussed. There are several studies that have identified stress

and different emotional responses in staff (Dransart, Gulfi, & Gutjahr, [2015](#)). Suicide, interpreted as a relief and logical based on the patient's life situation, raises questions about how the MHPs act and care for these patients, an issue that needs to be further elucidated. The results may be seen as the staffs' evaluation of the patients' life, described without purpose. On the other hand, it may be MHPs coping strategy to facilitate continued patient interactions. Suicidal behaviour was found to evoke feelings of being emotionally strained, and psychological pain (Hagen et al., [2017](#)). The MHPs' statements show how difficult it is to predict whether a person will take their own life or not. Nurses and other caregivers must have great respect for the unpredictable and be vigilant, even if the patient does not follow a pattern described in the literature. Suicide is often very difficult to predict and is often followed by negative emotional reactions in nurses (Bohan & Doyle, [2008](#)), such as feeling emotionally strained or in psychological pain (Hagen et al., [2017](#)). This indicates the need for sufficient formal support to be able to regulate emotions and feelings when caring for these patients.

4.1 Method discussion

Having three interviewers may be viewed as a limitation to the study as their interview techniques may have differed. To minimise any associated risks, the authors discussed all interviews carefully in order to understand the data. The authors have similar backgrounds to psychiatric nurses and a good contextual understanding. The transcriptions from the interviews were shared continually among the authors during the data assessment.

Coreq, a 32-item checklist for qualitative research, guided the method description and how the data were prepared and reported (Tong et al., [2007](#)). In qualitative studies, the depth of the data is often more important than the number of people interviewed. The participants belonged to a specific group that all had experience of a patient who had taken their own life but also showed variations regarding sex, workplaces, age and professions. Twelve participants were considered as sufficient information power related to a broad study aim, an in-depth analysis approach and experienced interviewer (Malterud, [2016](#)). A limitation is that this study highlights MHPs' experiences of why patients take their own life during ongoing care. It is therefore important to bear in mind that their experiences are not relevant to those patients who take their lives outside psychiatric care. However, the results are still of interest as they contribute experience-based knowledge that can help us to expand our understanding of why patients take their own life during ongoing care. However, the reader must keep in mind that the MHPs' experiences are based on their retrospective reflections, which may affect their interpretations of how MHPs experience the patients' suicide. It is not possible to say with certainty that these expressions of patient's suicide are possible to make conscious before a suicide. On the other hand, it is impossible to carry out interviews before the suicide, as suicide is difficult to predict (Bohan & Doyle, [2008](#); Hagen et al., [2017](#)). To obtain a complementary picture of the phenomenon, it would be important to study individuals who have made attempts to take their own life and survived to reconsider their experiences.

The interviews were conducted in three different regions to minimise the risk of the outcome reflecting a prevailing care culture from a specific department (Polit & Beck, [2012](#)).

There was a large spread of age and work experience of the informants in this study, which increased the chance of obtaining different opinions and experiences, and this was seen as strength of the study. Most importantly, participants were chosen based on their suitability and the experiences they could share (Patton, [2015](#)). Trustworthiness was also based on how well the themes covered what the respondents said and that relevant data were included and

irrelevant data excluded (Polit & Beck, [2012](#)). In order to strengthen the credibility of the results, the themes were strengthened with quotes. There is variation between and within countries regarding how accessible and structured the mental health care is (Patel, [2011](#)). In some countries, people with mental health problems mainly seek traditional healers who search for explanations and treatment methods other than those used in the western biomedical sector (Helman, [2007](#)). This study was conducted in a western society, so the transferability of the results may be limited. To make it possible for the reader to decide whether the results are transferable to a similar context, a clear description of the participants and the environment in which the data collection took place and the analysis process are given (Patton, [2015](#)).

5 CONCLUSION

The MHPs can physically feel the patients' borderline struggle between life and death. They experience how patients lose the possibility of having a worthwhile life when they realise the difficulties they have in relation to starting a family, getting an education or meeting basic needs such as controlling their own body and mind. The MHPs describe a darkness within the patient and how patient's life is fragile. When life is without meaning, empty and hopeless the patient may be at the end of the road without the possibility of retrieval. Altogether, suicide may appear as logical based on the patient's life circumstances and may be understood as a relief.

6 RELEVANCE TO CLINICAL PRACTICE

The clinical implication of this study is that mental health professionals need to explore the darkness of the patients' lives and their dignity. Staff needs sufficient support to dare to talk about this, in addition to looking at statistical background factors to assess whether the person is suicidal or not. Probably, we should take advantage of the fact that the patients' emotions can sometimes be transferred on to the MHPs. The MHPs experience feelings of sadness, hopelessness and darkness within themselves, which makes suicide in retrospect appear as logical. The MHPs' tacit knowledge may therefore be used in order to strengthen often uncertain suicide risk assessments. Some may argue that this will be too arbitrary. Nevertheless, we argue that the tacit, experience-based knowledge should be recognised and valued, especially when other ways have proven not to be better.

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CONFLICT OF INTEREST

The authors report no conflict of interests.

DISCLOSURE

The authors have confirmed that all authors meet the ICMJE criteria for authorship credit (www.icmje.org) as follows: (1) substantial contributions to conception and design of or acquisition of data or analysis and interpretation of data, (2) drafting the article or revising it

critically for important intellectual content and (3) final approval of the version to be published.

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