2004

Suicide Assessment by Psychiatric Mental Health Nurses: A Phenomenographic Study

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SUICIDE ASSESSMENT
BY
PSYCHIATRIC-MENTAL HEALTH NURSES:
A PHENOMENOGRAPHIC STUDY

by
JOHN M. AFLAGUE

A DISSERTATION SUBMITTED IN PARTIAL FULFILLMENT OF THE
REQUIREMENTS FOR THE DEGREE OF
DOCTOR OF PHILOSOPHY
IN
NURSING

UNIVERSITY OF RHODE ISLAND

2004

DOCTOR OF PHILOSOPHY DISSERTATION

OF

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2004

Abstract

Suicide is the eleventh leading cause of mortality in the United States. This study explored suicide assessment by psychiatric nurses. The primary aims of this study were to gain an understanding of nurses' conceptions regarding suicide and suicide assessment, describe the strategies of suicide assessment adopted by psychiatric nurses, and contrast these to contemporary standards and practice guidelines of suicide assessment.

The research design was an inductive descriptive phenomenographic study. The nurse participants consisted of a snowball sample of six psychiatric nurses practicing in two psychiatric settings. The data were collected through participant observations of nurses' assessing patients and semi-structured in-depth interviews with nurses regarding their assessments of actual cases and vignettes.

The participants in the study while performing suicide assessments relied on several different strategies among the common 10 categories that emerged as the core set of strategies. In most cases the nurses used between four to six different strategies in combination rather than relying solely on one specific strategy. However, the strategies used in suicide assessments by these nurses did not cover the areas identified in the standard guidelines in a comprehensive or all-inclusive manner, suggesting that the nurses were not systematic in their assessments. Out of the 10 categories, four have been linked to qualitative differences in suicide risk assessment.

Namely, 1) reliance on exemplars, 2) reliance on intuition, 3) reliance on the assessments of other professionals, and 4) reliance on related stories.

The characteristics of the 10 categories of description regarding suicide assessment could be classified into three dimensions: (a) *the Knowledge Dimension*, (b) *the Method Dimension*, and (c) *the Reference Dimension*. These *Dimensions* provide a “structure of suicide assessment” used in nursing practice by the participants of this study.

The findings of this investigation are descriptive and were discovered in the nurses’ practice. The results do not address correct or incorrect ways of practicing. However, the findings provide knowledge about actual nursing practice. This descriptive work can serve as a foundation for the development of a theory of nursing assessment. The findings have implications for nursing knowledge development, practice, education, administration, and research.

Acknowledgements

The completion of this dissertation could never have been accomplished alone. There are numerous individuals whom I wish to acknowledge. Given space limitations, I will attempt to recognize those who have especially contributed to this endeavor and hope that I do not omit anyone. First, I am grateful to the participants of this study and their affiliates for without their willingness to participate and generous time this research would not be possible. Their participation will positively contribute to nursing and quality client outcomes.

I am particularly indebted to my dissertation committee members who provided me with expert guidance, inspiration, and support throughout this challenging, rewarding, and often frustrating process. Dr. Hesook Suzie Kim, my major professor, made a commitment to work with me in attaining my goal and introduced me to the phenomenographic research method. Without her in-depth knowledge, expertise, and advice, I would not have fulfilled this commitment. Dr. Ginette Gosselin-Ferstz, my second reader, similarly provided me with invaluable time, contacts, resources, insightfulness, inspiration, and motivation. I am grateful to Dr. W. Grant Willis, Dr. James F. Campbell, and Dr. Jean Miller whose thoughtful consideration of my work and sharing of unique perspectives and expertise have significantly contributed to this project.

I am thankful to the faculty and staff of the University of Rhode Island and my classmates who provided me knowledge, resources, and support. My

gratitude is extended to my colleagues at Rhode Island College for allowing me the flexibility so essential to a rigorous academic pursuit. Too numerous to mention, the faculty and staff at Rhode Island College are a special group whose contributions have been countless. I am thankful for the students I have had the privilege of working with as they have been a driving force in this process, too.

This endeavor would not have been possible without the unconditional love, support, and sacrifices of my family and others. My mother who instilled the importance of education in me, prayed for me, and with utmost patience, understanding, and support lived through this experience with me daily. When I was a child, my father (albeit, now passed away), affectionately referred to me as “professor;” this encouraged me to pursue the earned doctorate, a requisite to teaching nursing for which I have a special passion. My siblings and their families have also given me much needed support. I am also grateful to Konstantin Linnik, David Chicoine, Shellie Simons, Michael Ridolfi, Elsa Shuk Fong Chen, and many others for their understanding, availability, patience, listening, encouragement, and faith in my abilities.

Additionally, I am thankful to the Delta Upsilon Chapter, Sigma Theta Tau International Honor Society of Nursing, The Heather Fund, and The Janet Dunphy Scholarship (Massachusetts Nurses’ Association, District 5) for their generous financial assistance.

And, last but not least, this research is dedicated to victims of suicide and those who have experienced the aftermath of suicide.

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CHAPTER I

STATEMENT OF THE PROBLEM

Introduction

Suicide is the eleventh (Centers for Disease Control and Prevention, 2002) leading cause of mortality in the United States, accounting for more than 30,000 deaths annually (1.4% of all deaths). For adolescents, suicide is the third leading cause of death. Three times more males than females complete suicide in the United States annually. The suicide rate for whites is double as compared to nonwhites (i.e., African-American and Hispanics). When these rates are applied to the number of white and nonwhites in the United States, 72% of annual deaths by suicide are committed by white males, 19% by white females, 7% by nonwhite males, and 2% by nonwhite females (National Center for Health Statistics, 1992). Suicide rates for adolescents have increased threefold since 1955, and individuals over 60 years have a higher rate than people between the ages of 25 and 55 years old (Clark & Fawcett, 1992). White older men (over 80 years old) are at the greatest suicide risk of all ages, gender, and racial groups. The increased suicide rate in older people is particularly noteworthy since they represent half the clientele for many clinicians (Whall & Colling, 2001). Statistical data regarding suicide are often underestimated. This may be related to the stigma associated with suicide, guilt of significant others, and concern for loss of insurance benefits.

Fifty to 65% of individuals who attempt suicide have contact with clinicians and generally communicate their suicide ideation to someone

(including nurses) in the months preceding attempts (Fawcett, Clark, & Busch, 1993; Goh, Salmons, & Whittington, 1989; Morgan & Priest, 1999; Rich, Young, & Fowler, 1986). Brown, Jones, Betts, and Jingyang (2003) studied 3,500 mental health professionals and 43,000 patients finding clinicians missed early suicide signs in adults 57% of the time compared with patient self-reporting of suicidality via questionnaire. When practitioners were informed of the *differences* between their assessments and the client responses, the error rate dropped to 39%. This reduced “error rate” was similar for adolescents and resulted in a combined statistical improvement in risk assessment of 29%. Similarly, a root cause analyses of 17 attempted and completed suicides identified inadequate patient assessment, knowledge deficits, and poor communication as contributing factors (Dlugacz, Restifo, Scanlon, Nelson, Fried, Hirsh, Delman, Zenn, Selzer, & Greenwood, 2003). Other studies (Somers-Flannagan & Somers-Flannagan, 1995; Miller, 1978) have shown that even when clients have expressed suicidal ideation (via a verbal or behavioral clue), clinicians have neglected to establish or prevent intent. Furthermore, some clinicians philosophically adhere to the belief that individuals have the right to suicide; still others feel suicide is unpreventable (Repper, 1999). Therefore, the conceptions regarding suicide and assessment strategies adopted by nurses may play a crucial role in the quality of individual nurses’ suicide assessments and client outcomes.

Improved understanding of how nurses assess suicidality has significance to the public health problem of increasing suicide rates.

Theoretically, this study could contribute to knowledge development in nursing with a focus on practice (for example, in the area of deliberation and enactment phases in the nursing practice domain identified by Kim [1983, 1987, 2000]). Pragmatically, there is value in gaining better insight into nurse's conceptions of suicide assessment with the goal of suicide prevention and early intervention.

The available statistics and findings make suicide a major national public health problem. As a result, for example, the U.S. Senate Special Committee on Aging held Congressional hearings entitled: "Suicide and the Elderly: A Population at Risk" (1996). The report given by the Director of the National Center for Injury Prevention and Control of the Centers for Disease Control and Prevention (CDC) identified suicide in older people as a vital public health preventable problem. The CDC's goal is to decrease the incidence of suicide in older people using the public health approach. This suicide prevention approach combines four primary activities: (a) surveillance to identify trends and epidemics and differential rates of suicide, (b) research to identify the sequence of causes in the chain of suicide, (c) design and evaluation of interventions to stop this chain and prevent suicides, and (d) program implementation encompassing demonstrated successful interventions. Other initiatives have developed to address other high-risk groups, such as children and adolescents (Horowitz, Fallon-Smith, Levin, & Klavon, 2002), older white males (Miller, 1978), and schizophrenics.

In 1999, Surgeon General David Satcher presented a blueprint to prevent suicide. *The Surgeon General's Call To Action To Prevent Suicide* (U.S. Public Health Service, 1999) outlines actions that can be implemented by individuals, communities, and policymakers. Other initiatives also highlight suicide as a priority national health problem (U.S. Department of Health and Human Services, 1998; U.S. Senate, 1997). For example, Healthy People 2000 has targeted older white males as a group most at risk for suicide and has set a goal for a 15% reduction in the rate of suicide for this group. Similarly, in an attempt to attain the "Healthy People 2000" objective of decreasing "suicide deaths to no more than 10.5 per 100,000 residents" (Simmons, Peterson, & Hale, 1999, p. 337), community-based intervention strategies have emerged. Such federal initiatives address the implications of suicide on public health and impact on nursing practice.

Suicide is complex and multifaceted. This adds to the challenges of accurate suicide assessment. As Bongar (1992) states, "assessing the reliability of individuals reporting on suicidal inclinations is a matter of clinical judgment that goes beyond codified criteria" (p. 207). Furthermore, no one has been able to demonstrate "that any standardized suicide risk prediction scale can pick out persons who go on to die by suicide in samples beyond the sample that generated the scale" (Clark, Young, Scheftner, Fawcett, & Fogg, 1987, p. 32). Bongar (1992) further states, "[t]he more commonly known suicide assessment instruments [appear] to be used infrequently and most of

the traditional instruments are rated as having limited usefulness” (Bongar, 1992, p. 148).

Because there is a lack of specific precise measures and standardized procedures to unmistakably determine whether an individual is at risk for suicide, suicide assessment is especially problematic and challenging. Although major advances have been made in the area of suicide assessment, there remains a lack of knowledge regarding suicide assessment. There is a need to continue with the efforts to understand and address the emerging trends in suicide and delineate better ways to assess and prevent suicide.

Suicide Assessment Methods and Instruments

“Customary” Methods for Suicide Assessment

Jobes and colleagues found that psychiatrists, psychologists, and social workers (interestingly, nurses were not included in the study) “reply primarily on some form of clinical interview to assess suicide (specifically on certain valued questions and observations)” (Jobes, Eyman, & Yufit, 1990, p. 148). “...As Coombs et al. (1992) have shown, many clinicians fundamentally do not even ask about suicide and routinely fail to conduct and document basic assessment of suicide risk. Still other data suggest that some outpatient clinics have explicit exclusion criteria for suicidal patients (Benstein, Feldberg, & Brown, 1991). It is striking to note that research examining empirical treatments for suicidality is so scant because most treatment research protocols routinely exclude high-risk suicidal patients (Linehan, 1998)” (Jobes, 2000, pp. 9-10).

Recent studies, have also found that, although the overwhelming majority of school counselors are familiar with adolescent suicide risk factors and believe that their role is to identify at risk students, only 1 in 3 reported feeling competent in identifying a student at risk (King, Price, Telljohann, & Wahl, 1999; Coder, Nelson, & Aylward, 1991). Only 74% of counselors studied felt knowledgeable about school district policy and procedures on suicide. Additionally, only 58% reported knowing how to negotiate a no-suicide contract and less (51%) reported understanding crisis theory and its relationship to crisis intervention. Furthermore, myths, misinformation and/or misunderstanding of suicide continue to exist. For example, "between one-half to two-thirds of respondents incorrectly believed that entering puberty at a late age, being financially disadvantaged, being obese, and having low grades were risk factors" (King & Smith, 2000, p. 404).

Williams and Morgan (1994) describe negative attitudes and misconceptions surrounding the feasibility of suicide prevention (e.g., some practitioners believe that individuals should be allowed to commit suicide if they desire and that suicide is often not preventable). However, Morgan and Evans (1995) found that providing education (on the incidence, assessment and management of suicide) significantly reduced such negative attitudes (Repper, 1999; Morgan & Evans, 1995).

Contemporary suicide assessment practice varies between and among clinicians. Assessment can range from a comprehensive mental status assessment (including thorough qualitative data and/or use of quantitative

instruments and consultation) to the use of intuition ("I know the patient.") or apparent absence of direct suicide assessment. Assessment of subjective data makes accurate suicide assessment another particularly challenging problem. In particular, we do not currently have a very good depiction of what really is happening in actual clinical practice with nurses in their assessment of suicidality.

Contemporary suicide assessment practice guidelines, although invaluable, are often complex, vary across settings and population and are not all inclusive. Such contemporary suicide assessments, depending on the clinician, could consist of a systematic comprehensive collection of the following data:

A. Determination of the presence of epidemiological and sociodemographic risk factors. This would include, but is not limited to, high-risk populations, such as older people, single, white, male gender, those living alone, etc. If clinicians rely exclusively on risk factors as the basis of their suicide assessment, for example, erroneous clinical judgment could result (i.e., low risk does *not* mean no risk).

B. Determination of the presence of stressors. This would include, but is not limited to, changes in personal, social, occupational, and/or academic life spheres.

C. Depression screening with associated agitation and/or anxiety. Many clinicians use the SIG-E-CAPS acronym (Prescribe Energy Capsules) (Wise & Rundell, 1988) as a guide to assessing depression with

anxiety/agitation. These areas include assessing (S) sleep disturbance, change in (I) interest (anhedonia), (G) guilt (excessive guilt, worthlessness, hopelessness, helplessness), (E) energy level (fatigue or loss of energy), (C) concentration difficulties or indecisiveness, (A) appetite change (>5% weight loss or gain), (P) psychomotor agitation/anxiety or retardation, and (S) suicide (ideation, plan, or attempt). The extent of this assessment can vary in depth and breadth among and between clinicians. For example, some clinicians would incorporate additional in-depth questions regarding insight, judgment, impulsivity, intent and plan, and means and access (e.g., having weapons or hoarding medication).

D. Substance abuse screening. Since denial and minimization are major defense mechanisms used by substance abusers, the client's reliability regarding substance abuse adds to the challenge of the comprehensive (often inaccurate or incomplete) assessment process.

E. More specific assessment for suicide. Other suicide assessment strategies may include the use of various quantifiable instruments and/or would entail directly asking the client a variety of questions including "Have you had thoughts of death or of killing yourself?"

As a guide in specific suicide assessment, many clinicians also rely on the areas identified in the SADPERSONS SCALE (Patterson, Dohn, Bird, & Patterson, 1983) [Appendix A] and/or the areas within the "SLAP" acronym, which stands for specificity, lethality, availability, and proximity (Sommers-Flanagan & Sommers-Flanagan, 1995).

There are many instruments that have been developed and are being used by practitioners both in nursing and in the psychiatric-mental health field for suicide assessment. These are reviewed briefly in the following section in order to provide a background of how suicide assessment is performed in practice.

Nursing Scales for Assessing Suicidality

A. “Suicide/self harm assessment” (Medical University of South Carolina, USA). Stuart (2001) provides a “Suicide/Self Harm Assessment” tool focusing on “key factors,” including ability to contract for safety, suicide plan, lethality, elopement risk, suicidal ideation, attempt history, select symptoms, and current morbid thoughts. This nursing developed tool combines quantitative and qualitative components. The scoring is divided into high risk (a score of 10 or greater), moderate risk (a score of 4-9), and no precautions (a score of 0-3). Although reportedly used in select practice settings, there is no available documented evidence of the tools reliability and validity. Furthermore, the “RN Subjective Appraisal of Risk” relies on the RN’s ability to accurately appraise the client’s trustworthiness, a task that can be challenging, particularly with clients who are guarded, withholding and paranoid.

B. “Guidelines for urgent mental health referrals” (North Solihull, UK). In 1996, Tumney (2001) and a multidisciplinary team developed nurse led guidelines for urgent mental health referrals based on “good practice and collaboration in accordance with two of the standards identified in the National

Service Framework for Mental Health” (Turney, 2001, p. 42). Unfortunately, to date, this writer has been unable to access these guidelines. However, in the currently available literature, it is unclear as to what “good practice” entails. Furthermore, in addition to acknowledging that suicide prediction is difficult (Tanny, 1995), the urgent care team is only available during “traditional working hours” and caters to “the local population” (Turney, 2001), thus, limiting its utility.

C. “Suicide prevention nursing protocol” (Bay Pines, FL). In 1997 Florida’s Bay Pines Veteran Affairs Medical Center established a “research-based suicide prevention nursing protocol.” This protocol was developed by a team consisting of: a psychiatric nurse practitioner, a mental health nurse specialist, two mental health staff nurses, an education specialist, and a training specialist. The purpose was “to improve the quality of care while reducing the legal vulnerability of health care providers and the facility” (Robie, Edemon-Hill, Phelps, Schmitz, & Laughlin, 1999, p. 53). According to the authors, “this ensues that a standard is used to assess – and to intervene with – all patients at risk for suicide” (p.53).

Although this protocol and associated basic algorithm may have clinical usefulness, it is unclear as to whether it was developed with a theoretical framework, what “research-based” criteria was used, if the protocol has been tested, and whether utility extends beyond the stated population.

Furthermore, the authors provide a seemingly complex unsystematized list of behaviors and risks (including the SAD PERSONS scale) [Appendix A] which

might be impossible to memorize or incorporate in clinical practice and do not provide a comprehensive mechanism for systematically assessing the suicidal client.

D. "Degree of suicidal risk" (Los Angeles, CA). In a noteworthy attempt to advance nursing suicide assessment, Hatton, Valente, and Rink (1977) and, later, Hatton and Valente (1984) proposed a "Degree of Suicidal Risk" assessment scale. This scale focuses on the assessment of specific behaviors or symptoms resulting in a rating from low to moderate to high intensity of risk. In addition to differentiating emergency versus long-term risk ratings (e.g., "emergency risk rating ... defined as the potential of the person for killing himself or herself within the next 24 hours; and the long-term risk rating ... defined as the likelihood that a person will kill himself or herself within the next two years [p.57]), the authors identify the "three most significant assessment factors that identify for the caregiver the difference between these two ratings ... (1) the coping strategies, (2) the life style, and (3) the suicidal feelings of the client" (p. 56). Although case examples are provided as illustrations, the behavior or symptoms and "three most significant assessment factors" are extensive areas to cover in a routine assessment and the scored ratings of low, moderate, and high intensity risk are subjective ratings and unclear. The authors, also, address the "intuitive" aspects in suicide assessment. Such intuition could yield fatal outcomes should clients be erroneously assessed.

E. "A scale for assessing suicidal potential" (Los Angeles, CA). In "Suicide Intervention by Nurses" (Miller, 1982), "A Scale for Assessing Suicidal Potential" is provided as a prototype assessment scale. As stated by the developers, the scale "is only useful in helping you to *estimate* suicidal potential, and therefore is not meant to be definitive" (p. 57). The scale is somewhat extensive, complex, and lengthy and questionably pragmatic. Furthermore, the low, medium and high-risk ratings are the arithmetic mean which is "only meant to be suggestive, not conclusive" (p. 58).

Select Non-Nurse Developed Quantitative Instruments

Although numerous quantitative suicide assessment instruments have demonstrated "robust" reliability and validity (e.g., Beck Scale for Suicidal Ideation, Beck's Suicide Intent Scale, and Beck Depression Scale), quantitative scores interpreted alone can be dangerously misinterpreted and inaccurate as can qualitative assessment or a combination of inaccurate quantitative and qualitative assessment.

As Bongar (1991) highlights, "[a] note of warning is needed here: Maris (1988) cautioned that one needs to be wary of reduction (biological, psychological, or social) when it comes to the study of the suicidal patient, that suicide is a symptom, not a diagnosis, and that, although the state of being suicidal can be analyzed, the act of suicide cannot. This cautionary note reverberates throughout the suicidology literature. 'Suicidal thoughts, like all human thoughts, are experiential actions' (Maris, 1988, p. xii). Shneidman (1988) noted that "study of suicide is multidisciplinary – a never-completed

circle, containing many legitimate sectors or fields or approaches" (p. 5).

Pfeffer (1988) agrees, stating that "suicidal behavior is a complex, multidimensional phenomenon that can be understood from a variety of key vantage points: psychosocial, sociocultural, constitutional-biological, any many others" (p.21). Thus, there is no one ideal standard nor is there a static constellation of standards that can be applied in all areas of suicide. Similarly, as Bongar (1992) states, "No suicide scale is an ideal screening instrument. One must use a scale that has the best normative data for the population in question and that is oriented toward the particular information most needed (e.g., degree of hopelessness, severity of suicidal ideation, and suicide intent)" (p. 128).

In sum, although such "scales" are potentially useful, they are not all-inclusive and could provide the clinician with a potentially "deadly" false sense of security. The following selected quantitative instruments are illustrative of the more familiar and frequently used.

A. *Suicide intent scale.* The Suicide Intent Scale (Beck, Schuyler, & Herman, 1974) is a semi-structured interview administered by a trained clinician that assesses suicidal intent from data collected reflecting the intensity of the attempter's desire to die at the time of the attempt. The scale, divided into two sections, contains 15 items rated in intensity from 0 to 2. The first section, "objective circumstances related to the suicide attempt," describes the person's behavior and events surrounding the attempt. The second section details the person's thoughts and feelings at the time of the

attempt. Each item is rated on a 3-point scale of severity and a total score is the sum of the scores from the 15 questions. The Suicide Intent Scale has been shown to have an inter-item reliability ranging from .91 (Beck, Morris, & Beck, 1974) to .95 (Beck, Schuyler, & Herman, 1974).

B. Scale for suicide ideation. Beck and colleagues (1979) developed the "Scale for Suicide Ideation" to quantify the intensity of current conscious suicidal thoughts and plans. This 19-item scale is scored by a trained interviewer based on a semi-structured interview. Three alternative statements are scored (from 0-2), and the total score is the sum of the scores for each item. The Scale for Suicide Ideation covers 5 domains: (1) attitude toward dying and living; (2) suicide wish or ideation; (3) actualization of contemplated attempt; (4) nature of contemplated attempt; and (5) background factors. "Internal consistency was found to be .89 and interrater reliability .83" (Bongar, 1992, p. 130). This scale discriminates among groups varying in degree of suicidal ideation. The Scale for Suicide Ideation has been modified (Miller, Norman, Bishop, & Dow, 1986) for paraprofessional administration. Unlike the Hopelessness Scale, the Scale for Suicide Ideation is only recommended for use with adults because there lacks research on its utility with adolescent populations.

C. Suicidal ideation questionnaire. Reynolds (1988) developed the Suicidal Ideation Questionnaire (SIQ) to assess an adolescent's severity and recent frequency of suicidal ideation. Forms for middle, junior, and high school students were designed primarily as *screening* instruments to identify

adolescents at risk of suicidal behavior. The junior high school version includes 15 items and the high school version 30 items.

The items consist of statements relating to ideas of self-injury, death, and suicide. The student is asked to answer each question according to how often a statement was "on my mind" during the past month, using a 7-point scale ranging from "I never had this thought" to "almost every day."

Interpretation is based on a total score for degree (severity) of suicidal ideation that is a sum of the item scores, critical items regarding specific thoughts and plans, and individual patterns. Reynolds (1988) suggests further suicidal risk evaluation for scores above a cutoff score or endorsement of 2 critical items on the junior high school version and 3 critical items on the high school version.

Although carefully constructed and one of the best suicide screening instruments for an adolescent population, the SIQ cannot be recommended for clinical use independently (Lewinsohn, Garrison, Langhinrichsen, & Marsteller, 1989). The instrument was developed with a sample of junior and senior high school students, thus, the scores from this general population are likely inappropriate for adolescent psychiatric inpatients (Bongar, 1992).

D. Suicide probability scale. Cull and Gill (1986) designed the Suicide Probability Scale to assess suicide risk in adolescents and adults. This 36-item questionnaire asks respondents to rate the frequency of occurrence for every item of a 4-point Likert Scale. However, instructions are

unclear about whether the respondent is to base the rating on current or past experiences.

"Hand-tabulated responses provide a total weighted score, a normalized total T-score, and a suicide probability score, which is the statistical likelihood an individual might belong to a population of lethal suicide attempters. ... Golding (1985) indicated that a factor analysis showed the scale items to be scattered among various factors and highly correlated so the subscales are not statistically sound or independent; hence they should be used with caution" (Bongar, 1992, p. 131).

E. Other Select Assessment Tools. The United Kingdom's NHS Health Advisory Service has developed a "thematic assessment process" (Williams & Morgan, 1994) that is meant to be *suggestive, not conclusive* and is *only an estimate* of suicide potential. Also, Gliatto and Rai (1999) provide a "management algorithm" for the evaluation and treatment of patients with suicidal ideation. Although addressing certain aspects of suicide assessment, this algorithm is not uniformly used in practice nor appears well known.

Commentary on Quantitative Instruments

Although standardized suicide risk assessment tools are readily available, Rice and Donnelly (1991) found that most clinicians do not utilize them. The authors provide several potential explanations for this trend: (a) some instruments are intended for research rather than practice; (b) extensive training is often involved to ensure competent administration of such instruments; and (c) most instruments are time consuming to accurately

administer. However, given that many individuals who ultimately commit suicide have had recent contact with clinicians shortly before their death, this finding emphasizes the challenges of suicide assessment in *routine* practice.

Furthermore, although many of the quantifiable suicide assessment instruments have documented “reliability” and “validity,” it is unclear whether some of these instruments have been developed with a theoretical foundation (cogency), which raises doubts as to the reported levels of reliability and validity. Still, while some instruments may have been developed based on theoretical frameworks and tested for reliability and validity, many have not been appropriately and rigorously tested and some instruments have been developed without well established theoretical foundations (i.e., atheoretical). Therefore, the quality of such instruments cannot be accurately evaluated and limitations in their application exist.

Additionally, some argue that quantitative instruments are reductionistic and negate the human aspect of suicide assessment (Jobes, 2000). Still, many of the available instruments are more appropriate in research or have been evaluated in non-clinical settings (Rice & Donnelly, 1991). That is, many quantitative instruments have been tested in controlled settings not equivalent to that of actual clinical practice.

State of the Art in Suicide Assessment

The abundance of assessment methods that have been developed to date indicates that there is no uniform standard of practice applied across various practitioners and settings. Although quantitative tools are available,

they are not used consistently. Qualitative ways of assessing seem to vary across individual settings and cases (i.e., quality seems to vary across settings and situation). Thus, there is a need to gain better knowledge about the assessment of suicidality in actual clinical practice. Although the problem of suicide assessment has been extensively researched, nurses have not been included in such studies (i.e., more typically, research has included psychologist, psychiatrist, school counselors, and psychiatric social worker as previously cited).

Clinical time constraints, the decreased time available to develop a therapeutic trusting relationship with clients, the limited use of clinical assessment instruments/tools, clinician knowledge deficit, or uneasiness asking direct questions have compounded the complexity of suicide assessment (Hirshfeld & Russell, 1997). Thus, there lacks clear understanding of suicide assessment in actual nursing practice (both with novice and expert/advanced practice nurses).

Select Clinical Practice Guidelines

Since the concept of suicide and the process of suicide assessment are exceptionally complex, no existing "practice guideline" can serve as the absolute (perfect) "standard of care." For example, *The American Family Physician* (1999) provides general guidelines for evaluating and treating clients with suicidal ideation yet acknowledges these guidelines are *not* absolute. Many other guidelines provide a similar disclaimer that they are neither official nor absolute.

Numerous suicide assessment practice guidelines have been developed. For the purpose of this study, The Harvard Medical School Suicide Assessment Protocol Guidelines (Jacobs, Brewer, & Klein-Benheim, 1999) [Appendix B] will be used as the primary practice guidelines for addressing research question #3 (How do the strategies of suicide assessment used by psychiatric-mental health nurses compare with current practice guidelines on suicide assessment?). As with Bongar's (1992) comprehensive practice guidelines, the guiding principle for the development of these guidelines is to provide a foundation of basic and critically essential clinical knowledge drawn from accumulated clinical wisdom, review of contemporary empirical findings, and extensive experience in managing the suicidal patient.

Bongar (1991) also emphasizes that the opinion of a respected colleague can be the best immediate 'cross-validity check' on the standard of care. Similarly, Shneidman's (1981) dictum is that "Suicide prevention is not best done as a solo practice" (p. 344), thus, emphasizing the critical nature of ongoing consultation in assessing and managing the suicidal client. Although appropriate professional consultation is vital, the introduction of possible human error remains.

Purpose of the Study

Research links suicide to misdiagnosis, under-diagnosis (under/mis-assessment) or undertreatment of depression, and clinicians continue to miss and/or insufficiently manage suicidal intent (Whall & Colling, 2001). Although

a large body of knowledge has accumulated in the field of suicidology, the strategies adopted by nurses in suicide assessment in actual clinical practice remains unstudied. This problem is particularly relevant to nursing practice, given that nurses are often the only or initial contact for clients (patients) and it is also nurses who assume around-the-clock accountability for patients. Furthermore, research has shown that nurses often have low comfort levels and limited knowledge in managing suicidal clients (Horowitz, Smith, Levin, & Klavon, 2002). Improved understanding of how nurses assess suicide has significance to the public health problem of increasing suicide rates.

The major aim of this research is to gain knowledge about the conceptualizations and nature and characteristics of suicide assessment by psychiatric-mental health nurses. This study employs phenomenography as the principle method to identify similarities and qualitative differences in the strategies used by nurses in suicide assessment. The specific aim of this research is to identify and describe categories of description used by nurses in suicide assessment. Enhanced understanding of how nurses conceptualize and assess suicide will provide a foundation for improving nursing practice and education.

Research Design and Research Questions

This research applied a descriptive qualitative inductive design using phenomenography as its orientation. The study design (Appendix C) adopted two key assumptions of phenomenography: (a) there are a finite number of qualitative different ways that individuals conceptualize phenomena, and (b)

an individual may not express all aspects of a conception (and conceptions can vary within the same individual at various times) [Marton, 1997; Sandberg, 1995]. Over 20 years of various phenomenographic studies support the first assumption (Marton, 1986; 1997). Regarding the second assumption, Sandberg (1995, p. 158) notes that, in some circumstances, a specific conception cannot be perceived in its entirety in data obtained from one individual, but only within data obtained from several individuals. Thus, phenomenographic researchers synthesize data from many individuals in order to better understand the different qualitative ways of conceptualizing the phenomena. Under these assumptions, the present study sought to discover different ways suicidality was conceptualized and assessed in clients by psychiatric-mental health nurses.

The following research questions were advanced as the guide for this research:

1. What are the understandings (conceptualizations) of suicide held by nurses in relation to suicide assessment?
2. What are the strategies of suicide assessment used by psychiatric-mental health nurses?
3. How do the strategies of suicide assessment used by psychiatric-mental health nurses compare with current practice guidelines on suicide assessment?
4. How do nurses perceive education and/or experience influencing their suicide assessments?

A snowball convenience sample of six psychiatric-mental health nurses currently working in two different psychiatric settings was recruited as the participants in the study. The study used participant observation of one assessment session by each nurse, three assessments of case scenarios (vignettes) for suicidality by each nurse, and in-depth, semi-structured interviews with the participants following each assessment. The data analysis followed the process suggested for phenomenography.

CHAPTER II

REVIEW OF THE LITERATURE

The Phenomenon of Suicide

Historical Perspective

A critical problem in suicide research concerns the definition of the phenomenon. Clarity of definition is essential to concept and theory development. The vagueness of the definition has obfuscated the understanding of the phenomenon.

"Suicide," a noun, implies a set of diverse behavioral actions and experiences. There are additional issues that add to this unclarity, for example, the definitions of "assisted suicide" and other types of suicide. Another problem is related to the lack of knowledge about suicide psychodynamics.

Numerous classifications of suicide, suicidal behavior (suicidality), and risk have been developed, contributing to inconsistencies in the definitions and complicating suicide research. Many typologies are impractical (e.g., Durkheim, 1950; Shneidman, 1985). Other taxonomies rely largely on inferential assessment of risk factors and identify suicide types that are not exhaustive.

Historically, suicide is a relatively new term. According to "The Oxford English Dictionary," Walter Charleton used the word, suicide, in 1651. Yet, Edward Philips, in his 1662 dictionary, "A New World of Words," asserts to

have coined the term. Before this, other words were used to describe suicide (Leenaars, 1988).

Many suicidologists have attempted to define suicide (e.g., Beauchamp, 1978, Graber, 1981, Windt, 1980) yet, according to Shneidman (1985), these definitions suffer from "intellectual overkill" (p. 16). Shneidman himself is not satisfied with the incompleteness of his relatively succinct definition of suicide as a self-intentioned, self-inflicted cessation. Suicide may also be defined according to its purpose (e.g., medical or legal). In countries reporting to the World Health Organization, for example, suicide is defined by a medical examiner.

Shneidman's (1985) text "Definition of Suicide" was an essential step in more effectively defining suicide. He asserts that clarification of the definition of suicide is sorely needed. As Shneidman states, *"Currently in the Western world, suicide is a conscious act of self-induced annihilation, best understood as a multidimensional malaise in a needful individual who defines an issue for which suicide is perceived as the best solution"* (p. 203). Thus, unlike some, Shneidman does not view suicide as a disease, immorality, neurological dysfunction, or biological anomaly.

The definition of suicide and related concepts in the literature (e.g., suicide, suicidality, suicidal ideation, parasuicidal behavior, and suicide risk) are generally poorly defined. They are often inconsistent, unclear, underdeveloped, overlapping, and evolving. It is critical for nursing science to further refine and define these concepts. Such knowledge development could,

for example, provide a firmer foundation for suicide assessment, prevention, and intervention.

Selected Specific Definitions

According to the World Health Organization (1977), suicidality and suicidal behaviors includes completed suicide, attempted suicide, and suicidal ideation (ideas, thoughts). Completed suicide refers to death from self-inflicted injury where there is evidence that the decedent intended to kill himself/herself. Suicide attempt refers to a behavior with a nonfatal outcome, for which there is evidential support (either implicit or explicit) that the individual intended at some (nonzero) level to kill himself/herself. A suicide attempt may or may not result in injuries. Suicidal ideation refers to any self-reported thoughts (ideation) of engaging in suicide-related behavior.

According to Miller, Segal, and Coolidge (2000), suicidal ideation is defined as “the thoughts one has about killing oneself” (p. 358) and is a critical risk factor for serious suicidal behavior (Reynolds, 1991). Similarly, the National Institutes of Mental Health (NIMH, 2001) states, “Suicidal ideation refers to any *self-reported* (italics added for emphasis) thoughts of engaging in suicide-related behavior. Some investigators also consider thoughts that are less explicit wanting to take one’s life (wanting to be dead, not wanting to awaken) as indications of ‘passive’ suicide ideation,” (Pearson, Stanley, King, & Fisher, 2000, p. 2). This approach offers a broader definition of suicide. Although the NIMH’s definition is more encompassing than others, it seems its reference to suicidal ideation as being “self-reported” is problematic because

of the potential for inaccuracy and unaccountability of self-reporting. Since clients often do not voluntarily self-disclose such personal ideation, grave outcomes could result from literal reliance on this definition. In addition, this definition also lacks a referent to an accurate measurement. Thus, the definition by Miller, Segal, and Coolidge is believed to be the most accurate, conceptually clear, and practical. However, since this definition also seems to lack precise measurement, it is also incomplete.

Spectrum of Suicidality

Suicidal behaviors range from ideas (ideation, thoughts) that are never acted on, suicide attempts of varying degrees, and completed suicide.

Suicidal behavior can be characterized as a spectrum ranging from fleeting suicidal thoughts (ideation) to completed suicide (Gliatto & Rai, 1999).

Suicidality is a global term and is used to describe behaviors related to suicide. According to Shneidman (1973, 1979), lethality is a synonym for suicidality, meaning the probability that a specific individual will commit suicide within a specified period of time. Suicidality can be conceptualized on a continuum, ranging from suicidal ideation, parasuicidal behaviors, and completed suicide.

Suicidality represents a spectrum of risk (likelihood) with an implicit progression in the seriousness of risk from thoughts (ideation) to specific plans, gestures or minor self-injurious acts to attempts with a range of potential lethality, and completed suicide (O'Carroll, Berman, Maris, Moscicki, Tanney, & Silverman, 1996). Many possible social and environmental

explanations for regional and national variations in suicidal rates have been considered including social or political systems, population density, climate, latitude or annual light/dark cycles. Given such complexities and numerous variables, it is understandable that suicide is often viewed to be impossible to predict just as meteorologists' forecast (prediction) is not a 100% accurate prediction. Although some risks aren't modifiable, the accurate assessment of suicidality is critical since intervention could save lives.

Operational Criteria for Classification of Suicide

The "Operational Criteria for Classification of Suicide" (Jobes, Berman, & Josselson, 1987, p. 323) is provided below. Intentionality is the most difficult criterion to assess.

- I. *"Self-Inflicted:* There is evidence that death was self-inflicted. This may be determined by pathological (autopsy), toxicological, investigatory, and psychological evidence, and statements of the decedent or witnesses.
- II. *Intent:* There is evidence (explicit, implicit, or both) that at the time of injury the decedent intended to kill himself or herself or wished to die, and the decedent understood the probable consequences of his or her actions.
 - A. Explicit verbal or nonverbal expression of intent to kill self.
 - Implicit or indirect evidence of intent to die, such as the following:
 - a. Preparations for death inappropriate to or unexpected in the context of the decedent's life.
 - b. Expression of farewell or the desire to die or an acknowledgment of impending death.
 - c. Expression of hopelessness.
 - d. Expression of great emotional or physical pain or distress.
 - e. Effort to procure or learn about means of death or to rehearse fatal behavior.
 - f. Precautions to avoid rescue.

- g. Evidence that decedent recognized high potential lethality of means of death.
- h. Previous suicide attempt.
- i. Previous suicide threat.
- Stressful events or significant losses (actual or threatened).
- Serious depression or mental disorder" (Jobes, Berman, & Josselson, 1987, p. 323).

Given the complexities and inherent problems in suicidality and risk as concepts, suicide assessment cannot assure a high degree of predictability. Suicide assessment is problematic in terms of prediction in several respects. For example, it may be impossible to obtain complete data when patients intentionally or unintentionally do not reveal important information to clinicians or due to changes in client's psychological states. A challenge for accurate suicide assessment is in obtaining critical information associated with suicidal behavior (Neuringer, 1974).

Suicide Risk

Suicide is multifaceted and has been associated with numerous risk factors, antecedents, and correlates. Risk factors seldom act independently to increase risk. Certainly, many individuals may have one or more risk factor(s) and not be suicidal (Moscicki, 1999). Similarly, an individual may be without "identifiable" risk factors and be suicidal (i.e., no indication/identification of currently known risk factors does not mean no risk for suicidality/suicide.).

"The bulk of suicide risk research has focused on what can be referred to as formal measures of risk. First among them are demographic considerations detailed during the 1960's by Tuckman and Youngman (1963,

1968). These authors reported two follow-up studies after suicide attempts and enumerated 11 risk factors indicating the likelihood of subsequent suicide” (Bongar, 1992, p. 208). These are:

- a. age over 45 years
- b. male sex
- c. unemployment
- d. marital status of separation, divorce, or widowhood
- e. living alone
- f. physical health problems
- g. medical treatment within the prior 6 months
- h. diagnosed psychopathology including alcoholism
- i. attempt accomplished through violent means in contrast to overdose
- j. having left a suicide note
- k. history of suicide attempts

“Those individuals, for example, who scored on 10 or 11 of these factors were found to have a tenfold increase in suicide compared to all other suicide attempters” (Bongar, 1992, p. 208). Although the risk factors identified by Tuckman and Youngman (1963, 1968) in the 1960’s still essentially hold true currently, various sociocultural and other societal changes have since taken place, impacting the changing perspective of suicide, as well. For example, more recent research has identified temporal risk factors (e.g., seasonal or climate) [C.D.C., 1988].

The statistical identification of risk factors juxtaposed with the low suicide base rate has commonly measured a risk period (the time during which the factor has demonstrated to be associated with suicide) of 2 years or more (Addy, 1992; Neuringer, 1974). However, in practice the focus is on a significantly shorter risk period, as the practitioner is primarily concerned about the probability of suicide occurring during the days succeeding the

assessment (Mayo, 1998). As defined by Hirshfeld (1998), imminent risk of suicide is defined as within 48 hours.

According to Repper (1999), "The process of assessing the risk of suicide involves matching the individual with a set of risk factors which have been shown to correlate positively with increased suicide . . ." (p. 4). "Briefly, an emergency risk rating may be defined as the potential of the person for killing himself or herself within the next 24 hours; the long-term risk rating may be defined as the likelihood that a person will kill himself or herself within the next two years" (Hatton, Valente, & Rink, 1977, p. 57). Clarke and Fawcett (1992) expand upon this by making the distinction between imminent and long-term risks. It is important to recognize that risk factors are only one component of a comprehensive suicide assessment.

Nurses are routinely engaged in clinical risk assessment and decision-making occurs in the context of broader risk management (e.g., legal, organizational). The responsibility of nurses is to accurately assess and successfully manage clinical risks and to develop competent assessment strategies in assessing levels of risk under uncertainty. Crude predictions of the client being "unsafe" are seldom useful. What is valuable is a synthesis of what conditions constitute an increased risk. This necessitates a comprehensive anamnesis of the individual (present, historic, and futuristic orientations).

Risk assessment is incomplete until a risk formulation is made and a management plan devised to minimize risk. Assessment is useful only if it

yields better outcomes. Thus, a clear understanding of the concept of risk is essential. Risk is the probability of an adverse outcome. Risk factors are particular characteristics that individually or collectively yield increased risk.

Risk assessment is a prediction of the likelihood of a particular adverse outcome under specific circumstances happening within a specified time. Risk formulation is a process of organizing risk data, summarizing, and identifying risk factors. Risk formulation serves as the information foundation for risk management. The goal of risk management is to minimize the likelihood of particular adverse outcomes within the context of the overall management of a client, accomplish the ideal possible outcome, and deliver safe, effective, appropriate, timely care. Risk is not a static state and fluctuates. This necessitates ongoing assessment, especially during critical periods.

Assessment prediction is most precise in the short-term and is never perfect.

Risk assessment is an essential component of *every* clinical observation or assessment and should be incorporated in routine practice (Wilson, 1998).

Limits to risk assessment do occur and it is impossible to entirely eradicate risk. Even under the most ideal circumstances (using optimal assessment strategies and management modalities), adversity occurs. For example, epidemiological and actuarial measures are devised to identify high-risk *groups* and caution is needed when applying probabilities from these procedures to *individuals*. Furthermore, the history of the nurse-agent/assessor and the context of the situation (e.g., conceptions, attitudes,

culture, age, gender, and/or religious convictions) will impact the assessment process and outcome.

There is no definitive method of predicting suicidal behavior. While risk factors are comparatively common, suicide is uncommon (e.g., U.S. base rate of 0.011%) [Moscicki, 1997]. However, there are individual past and present patterns of risk factors that are highly suggestive and should alert a practitioner to possible suicide risk. The low incidence of suicide, additionally, contributes to the challenges of developing precise tools to accurately identify those at risk. As Neuringer (1974) notes, as one gravitates away from specificity and towards generality of prediction, accuracy increases yet utility decreases (i.e., endeavors to improve the sensitivity of risk-prediction measures yields more false positives). "The aim of science is to be able to make constant valid specific predictions. Any adequate assessment of suicidal risk technique should aim at the development of highly probable specific predictions. One might posit that the capacity to deliver such accurate specific and particular predictions is the hallmark of a truly useful assessment technique" (Neuringer, 1974, p. 6).

Arguing against a pure reductionistic risk perspective, Jobes (2000) states, "If we only consider risk factors we may fail to appreciate the utility of directly accessing and listening to the patient's own intrasubjective experience of being suicidal. Generally speaking, clinical assessments of suicidality often over emphasize a top-down (quantitative) risk-factor approach rather than

eliciting a bottom-up (qualitative) description of what it is like for a patient to be suicidal, in their own words" (p. 1).

In summary, nursing assessment of suicide risk and challenges to accurate risk assessment were addressed. A number of conceptual gaps were identified including the need for concept, knowledge, and theory development on suicide (including related terms), risks, and assessment. Implications for nursing are infinite (e.g., concept development, phenomenographic, and other research with clients, nurse-clients, and practice).

Select Theories of Suicide

The earliest theories of suicide were largely demonologic ("evil spirit") and theologic (religious) (Jackson, 1957). The major breakthroughs in the understanding of suicide were Freud's (1917) psychoanalytic conceptualization of suicide and Durkheim's (1950) sociological classification of suicide. In brief, Freud postulated the existence of 2 basic instincts, death instinct "thanatos" and life instinct "eros." Later, Durkheim classified all suicides into 4 kinds: altruistic, egoistic, anomic, and fatalistic.

Shneidman's Theory of Suicide

Edwin Shneidman is a Professor of Thanatology Emeritus at the University of California, Los Angeles and a founder of the American Association of Suicidology. The development of Shneidman's theory resulted from his work as a psychotherapist at the Suicide Prevention Center in Los Angeles which he founded in 1958 and from his theoretical analysis of many hundreds of

suicidal notes. Specifically, early in his work, he observed the three basic elements of a prototypical suicidal note:

- a. ".... I cannot take (stand, endure) this *pain* any longer...."
- b. ".... This is the *only* thing to do (way to go)...."
- c. ".... I am tired; I'd be better off *dead*...."

Key to Shneidman's theory of suicide is the concept of psychological pain that he termed, "psychache." Psychache is the introspective experience of negative emotions such as anger, despair, fear, grief, shame, guilt, hopelessness, loneliness, and loss (Shneidman, 1993). Shneidman develops the concept of psychache to explain the phenomenon of suicide. In his theory, one of the necessary elements of suicide is extreme psychache that the suicidal individual cannot endure. The source of psychache is frustrated psychological needs.

Shneidman (1991) proposed a "cubic model" of suicide (Figure 1). Included in this cubic model are three critical "P" factors ("3 P's"). These are (a) *press*, (b) *pain*, and (c) *perturbation*. These three factors are closely interconnected. *Press* ("pressure") represents those aspects of the actual and imaginary world, or environment that impinge on or affect the individual. *Pain* refers to psychological pain resulting from thwarted psychological needs. *Perturbation* is a general term meaning the state of being perturbed or upset. With respect to suicide, *perturbation* includes: (a) constriction, i.e., the reduction of the individual's perceptual and cognitive fields; and (b) "penchant for action," (p. 171) also referred to as "pull" which is best understood as the

lack of will power. The central assertion of Shneidman's theory is that although various areas in his three-dimensional cube may correspond to various psychological conditions, suicide occurs only within the depicted dark shaded area. Thus, if the intensity on at least one of the three dimensions is reduced to a level outside this area, the person will live.

Figure 1. Shneidman's Cubic Model of Suicide

Shneidman (1985) has identified and addressed in detail the 10 commonalities of suicide in order to define the boundaries of the phenomenon of suicide to which his theory applies. These 10 commonalities are listed below.

Conative:

- a. The common purpose of suicide is to seek a solution.
- b. The common goal is cessation of consciousness.

Situational:

- c. The common stimulus in suicide is intolerable psychological pain ("psychache").
- d. The common stressor in suicide is frustrated psychological needs.

Affective:

- e. The common emotion in suicide is hopelessness-helplessness.
- f. The common cognitive state in suicide is ambivalence.

Cognitive:

- g. The common perceptual state in suicide is constriction.
- h. The common action in suicide is egression.

Relational:

- i. The common interpersonal act in suicide is communication of intention.

Serial:

- j. The common consistency in suicide is with life-long coping patterns (pp. 121-151).

Shneidman does not frame his analysis in terms of what *type* of people commit suicide. Doing so ("profiling") would probably obfuscate our understanding of the phenomenon of suicide. The 10 common characteristics are helpful for conceptualization and characterization of the phenomenon of suicide, i.e., what suicide is and what it is not. As exemplified in his 1995 book, "Definition of Suicide," Shneidman illustrates how the phenomenon of

suicide can be distinguished from a related and similar phenomenon, namely, parasuicide or "subintentional suicide" (p. 216). Although the 10 commonalities of suicide are not necessarily apparent in each case of true suicide, at least some of them are manifested in each case. Thus, a clinician faced with a client who displays some of these characteristics must assess for other characteristics with the purpose of determining whether one is dealing with the true phenomenon of suicide. If the phenomenon of suicide is correctly identified, the role of the clinician is then to reduce stress by addressing the unmet needs of the suicidal individual. According to Shneidman's theory, suicide does not occur outside the dark shaded cube, therefore, reducing any of the 3 P's would minimize the risk of suicide. Although Shneidman's theory provides guidance for assessment of *press* and *perturbation*, until recently it lacked guidelines for assessment of psychological *pain*. Indeed, while *press* and *perturbation* can be assessed via objective external manifestations, the problem of assessing psychological pain is more elusive. Only recently Shneidman (1999) proposed the Psychological Pain Assessment Scale (PPAS). Shneidman acknowledges that the validity of the PPAS has not yet been empirically supported, but this instrument was found to be "useful." This scale is not used in routine nursing practice.

In short, Shneidman's theory primarily emphasizes defining suicide and suicide risks (i.e., commonalities) unlike Beck's theories (below) that are causal theories of depression and suicide.

Beck's Cognitive Theory of Depression/Suicide

Psychiatrist Aaron Beck, born in Providence, Rhode Island, is a self-proclaimed "pragmatist" (DiMarco, 2001; Weinrach, 1988). He is a graduate of Brown and Yale Universities. The historical roots of Beck's theory of cognitive therapy date back to 1956 when he experimentally found that in response to success experiences with graded task assignments, depressed clients seemed to improve rather than resist these experiences (Beck, 1964; Loeb, Beck & Diggory, 1971). These findings were inconsistent with Freud's psychoanalytic conceptualization of depression (Freud, 1917/1950). Thus, as a result of subsequent studies, Beck rejected the psychodynamic theory of depression and reformulated clinical depression as a disorder characterized by an intense negative bias (cognitive distortion). The cognitive theory of psychopathology later developed by Beck and colleagues (1999) has become a leading model for comprehending human cognition (including suicidal ideation) having been supported in more than 120 empirical tests (Alford & Beck, 1997).

Influenced by the cognitive theoretical contributions of Sullivan (1953), Bowers (1973), Lazarus (1972), and Kelly (1955) [in Beck, 1979], Beck and his colleagues also developed the Beck Depression Inventory (Beck & Beamesderfer, 1974), the Suicidal Intent Scale (Beck, Beck, & Kovacs, 1975), and the Scale for Suicide Ideation (Beck, Kovacs, & Weissman, 1979). It is unclear whether Beck conceptually and theoretically defines suicidal ideation. This raises questions about the reliability and validity of the latter instrument.

Additionally, Beck's theory of suicide does not account for all suicides (e.g., Durkheim's altruistic).

The central tenet of the cognitive theory is that human information processing (cognition, or "meaning construction") influences all emotional and behavioral experiences. The following are the theoretical axioms of this theory.

- a. The central pathway to psychological functioning or adaptation consists of the meaning-making structures of cognition, termed *schemas*.

"Meaning" refers to the person's interpretation of a given context and of that context's relationship to the self.

- b. The function of *meaning assignment* (at both automatic and deliberative levels) is to control the various psychological systems (e.g., behavioral, emotional, attentional, and memory). Thus, meaning activates strategies for adaptation.

- c. The influences between cognitive systems and other systems are interactive.

- d. Each category of meaning has implications that are translated into specific patterns of emotion, attention, memory, and behaviors. This is termed *cognitive content specificity*.

- e. Although meanings are constructed by the person, rather than being preexisting components of reality, they are correct or incorrect in relation to a given context or goal. When *cognitive distortion* or *bias* occurs, meanings are dysfunctional or maladaptive (in terms of systems

activation). Cognitive distortions include errors in cognitive content (meaning), cognitive processing (meaning elaboration), or both.

- f. Individuals are predisposed to specific faulty cognitive constructions (cognitive distortions). These predispositions to specific distortions are termed *cognitive vulnerabilities*. Specific cognitive vulnerabilities predispose persons to specific syndromes; cognitive specificity and cognitive vulnerability are interrelated.
- g. Psychopathology results from maladaptive meanings constructed regarding the self, the environmental context (experience), and the future (goals), which together are termed the *cognitive triad*. Each clinical syndrome has characteristic maladaptive meanings associated with the components of the *cognitive triad*. For example, all three components are interpreted negatively in depression. In anxiety, the self is seen as inadequate (because of deficient resources), the context is thought to be dangerous, and the future appears uncertain. In anger and paranoid disorders, the self is interpreted as mistreated or abused by others, and the world is seen as unfair and opposing one's interests. Cognitive content specificity is related in this manner to the cognitive triad.
- h. There are two levels of meaning: (a) the objective or *public meaning* of an event, which may have few significant implications for an individual; and (b) the *personal or private meaning*. The personal meaning, unlike

the public one, includes implications, significance, or generalizations drawn from the occurrence of the event.

- i. There are three levels of cognition: (a) the preconscious, unintentional, *automatic* level ("automatic thoughts"); (b) the conscious level; and (c) the metacognitive level, which includes "realistic" or "rational" (adaptive) responses. These serve useful functions, but the conscious levels are of primary interest for clinical improvement in psychotherapy.
- j. Schemas evolve to facilitate adaptation of the person to the environment, and are in this sense *teleonomic* structures. Thus, a given psychological state (constituted by the activation of systems) is neither adaptive nor maladaptive in itself, but only in relation to or in the context of the larger social and physical environment in which the person resides (Alford & Beck, 1997, pp. 48-56).

In summary, based on the axioms of the cognitive theory, people are prone to suicidality as a function of cognitive vulnerabilities (*faulty cognitive constructions*). The crucial pathway for suicidality is cognition (the *private* meaning of the individual). Suicidality is secondary to maladaptive constructed meanings regarding the self, environment, and future (i.e., the cognitive triad and its related conditional assumptions and compensatory strategies, coined the *suicidal belief system*). The suicidal belief system characterized by pervasive hopelessness often including, helplessness, poor distress tolerance, and unlovability varies among individuals depending on the context and content of the diverse psychological systems (i.e., *cognitive*

content specificity). The suicidal belief system exists at three discrete levels, the automatic or preconscious level, the conscious level, and the unconscious (i.e., metacognitive) level, with the conscious level predominantly amenable to psychotherapeutic change.

Comparison of Shneidman's and Beck's Theories of Suicide

The main distinction between Shneidman's and Beck's conceptualizations on the phenomenon of suicide is that Shneidman provides a model representing the necessary conditions, i.e., identifying "risks" in which suicide occurs but not specifying how suicidality develops, while Beck focuses more on how suicidality develops, i.e., addressing what the mechanisms are within the individual's constitution contributing to suicidality such as cognitive biases. Shneidman does not address what "type" of individual commits suicide, whereas Beck views individuals with cognitive distortions as being "predisposed" to suicide. Therefore, Beck's model assumes causality. Shneidman goes to great length at defining suicide while Beck's works seem to lack rigorous attempts at definition.

Both Beck and Shneidman emphasize environmental factors impinging on the individual. Both also include the importance of the following in their conceptualizations: psychological, interpersonal (relational), and cognition (including dichotomous thinking/ambivalence, hopelessness/helplessness, constriction, and intention). Although both theories address non-psychological factors (e.g., biochemical), they do not elaborate on these critical areas. It seems that bio-physiologic and chronobiologic factors are underemphasized.

For example, circadian rhythms as related to seasonal affective disorders such as depression with which suicidality is often associated are not considered. This overlooks the contemporary empirical data in support of pharmacotherapy and phototherapy in effectively managing affective disorders and suicidal manifestations. Since depressed clients are often in need of immediate life saving interventions (e.g., electroconvulsive therapy and psychotropics), exclusive reliance on cognitive interventions may be limiting. Furthermore, neither Shneidman nor Beck elaborate on cultural implications of suicide.

Shneidman's conceptualization is probably more useful for detecting at risk suicidal clients through judicious assessment of identified commonalities. Yet it does not provide specific guidelines for reducing psychological pain. Beck's theory is probably more useful for clinicians in providing guidelines for intervening with suicidal clients. Of course, given the ambiguities of the phenomenon of suicide, it would be erroneous to assume any single theory would account for all aspects of the phenomenon completely.

In short, Shneidman and Beck's conceptualizations of the phenomenon of suicide have been presented and contrasted. These theories, at minimum, provide a foundation for greater understanding of the phenomenon of suicide and management of at risk clients.

Assessment and Nursing

The result of a casual, nonrandom survey of nursing faculty, nursing students, and undergraduate and graduate psychiatric nursing texts suggests

that there is no specific suicide theory that is uniformly emphasized by them. More frequently, the focus is on integrated psychodynamic theories that may pertain to suicide assessment (e.g., Freud's notion of internalized rage). Similarly, suicide assessment education varies and can include incorporation of various aspects of suicide assessment from qualitative mental status assessment to empirically tested and theoretically supported use of quantitative instruments.

The problem of accurate suicide assessment is of particular significance to nurses given that they are often the initial or only health professional in contact with diverse clients in a variety of settings. Furthermore, nurses assume 24 hour accountability through clinical contact with clients for ongoing assessment as an integral aspect of nursing practice. Surely, suicide assessment has monumental relevance to nursing science and practice.

As previously discussed, although some nurses have proposed quantitative suicide assessment instruments, they tend to lack quantitative rigor or clinical utility. For example, the "Evaluation of Suicidal Potential" is based on 13 yes/no questions, with every 'yes' considered to increase the probability of suicide (Miller, 1982). However, there is no indication as to how many yes responses that can range between one and 13 increase the possibility of suicide. Others have conceptualized such assessment in a more qualitative fashion, assessing the degree of suicidal risk on a continuum, for

example in terms of low, moderate or high degree, and lethality (Hatton, Valente & Rink, 1977).

Most of the literature in nursing on suicide has focused on suicide-related intervention (Gournay & Bowers, 2000; Miller, 1982; Reid & Long, 1993; Repper, 1999; Robie, Edgemon-Hill, Phelps, Schmitz, & Laughlin, 1999; Samuelsson, Wiklander, Asberg & Saveman, 2000). Recently, interdisciplinary collaborative and integrative approaches to suicide prevention have been advocated (Jones, 2000; Rosenberg, 1999, Sommers-Flanagan & Sommers-Flanagan, 1995, Upanne, 1999). Collaborative efforts (e.g., a multidisciplinary approach utilizing professional consultation) in suicide research need to address the evolution of newer paradigms to replace outmoded existing assessment and treatment paradigms. Jobes (2000) addresses the impact of the clinical practice setting and views suicidality as essentially a relational phenomenon. "Fortunately, a new paradigm has begun to emerge in contemporary clinical suicidology, which objectifies suicidality and emphasizes the phenomenology of suicidal states. Moreover, from an increasingly empirical perspective, this approach is creating new and better ways to effectively assess and treat suicidal conditions" (p. 8).

As Jobes (2000) states, "Over the last decade a relatively small but determined band of clinician-researchers has set about trying to help us move beyond established but now outmoded assessment and treatment paradigms for suicidality. Indeed, we are now seeing within the subspecialization of 'clinical suicidology' an evolving, clinically informed and increasingly

empirically oriented knowledge base that is beginning to create whole new ways of thinking about clinical work with suicidal patients. Therein, a new paradigm is beginning to emerge" (Jobes, 2000, p. 11). In short, Jobes (2000) advocates the integration of clinical suicidology which incorporates the relational phenomenon associated in suicide assessment with an emphasis on the phenomenology of the client's suicidality. Similarly, Rosenberg (1999) advocates use of affective and action-based interventions in suicide prevention.

This Author's Experience—Problem of Prevention

The following briefly depicts this researcher's personal experience with suicide, its aftermath, and the problem faced by clinicians regarding suicide prevention. A patient, who had been admitted in an acute care, psychiatric, mental health care unit, was assessed as *not* suicidal and was given a 4 hour "therapeutic day pass" (unsupervised and outside the hospital confines). He was scheduled for an additional pass on the day of his suicide. Hence, his suicide was a complete surprise and unexpected by the clinicians. Neither the results of a complete battery of psychological (quantitative and projective) testing, nor the psychiatric multidisciplinary treatment team's assessment evaluated him to be suicidal. This misjudgment (or inaccuracy) in assessment led the nurses and other clinicians to not formally institute any special suicide preventive interventions on behalf of this patient. Furthermore, it was shocking to learn that the law authorities viewed this event as a potential homicide and considered staff negligent in their assessments or viewed the

staff or other patients culpable. This drastically disturbing incident suggests many potential problems faced by psychiatric-mental health nurses and clinicians in relation to suicide assessment and illustrates many ramifications of suicide assessment.

Studies and Theory on Conceptualization of Nursing Assessment

Kim (1983, 1987, 2000) provides a typology to explain and systematize nursing knowledge. Kim's typology comprises the practice, client, client-nurse and environment domains. The practice domain encompasses phenomena central to the nurse engaged in nursing practice (i.e., deliberation and enactment). The client domain emphasizes knowledge development specifically pertaining to the client, while the client-nurse domain focuses on client-nurse interactions and examines the provision of nursing care (e.g., interaction). The environment domain addresses phenomena in the context of environmental aspects as they influence the client, client-nurse, and practice domain phenomena.

To explicate phenomena in the practice domain, Kim partitions phenomena into four categories: (a) deliberative, (b) enactment, (c) knowledge utilization, and (d) professional role phenomena. This facilitates understanding of the nurse's role in caring for clients. Exploration of practice domain phenomena is imperative to understanding the essence of nursing practice and theory development.

According to Kim (2000), "Nursing practice in general is accepted as a set of activities performed by a nurse (an agent) toward the good of the client

in specific situations" (p. 130). In Kim's conceptualization, there are two philosophical orientations for nursing practice: (a) philosophy of therapy and (b) philosophy of care. Nursing practice is a multifaceted sequence of actions that is, also, divided into two dimensions: (a) deliberation and (b) enactment.

The deliberation dimension involves the nurse engaging in cognitive activities to devise a program of action. Deliberation involves assessment, definition of the situation, and establishing goals. It focuses on the assessment of the situation by the nurse, the nurse's judgment regarding the assessment, and the decisions pertaining to what needs to be done to meet the demands of the specific situation. Deliberation is linked to enactment and is oriented to an outcome. Clinical decision-making, diagnostic reasoning, information processing, prioritization, and nursing care planning are examples of phenomena in the deliberation phase (Kim, 2000).

Enactment is analytically separated from deliberation and involves actions and behaviors in a contextual practice situation. Kim's (2000) conceptualization of nursing practice was influenced by action science of Argyris, Putnam, and Smith (1985) and reflective practice of Schön (1983). "Variability in professional actions related to the professional's use of knowledge and cognitive processes that are used for translating 'what one knows' to 'what one does' is specifically at the core of questioning about the concept of practice" (Kim, 2000, p.130). Such variability is appropriate for phenomenographic and other studies.

Deliberation and enactment can be further viewed as holistic and particularistic levels of concept description. Of note, Kim (2000) includes assessment in both the deliberation and (particularistic) enactment dimensions. Assessment as a phenomenon consists of overlapping and iterative processes of deliberation (e.g., thinking, evaluating a plethora of complex data) and enactment (e.g., acting/action, "doing"). For example, assessment (i.e., obtaining information/data and critically analyzing the data to make clinical decisions) involves deliberating about what sorts of information to elicit and deciding which information is vitally important. Assessment, also, involves directly evaluating the client (e.g., enactment using quantitative instruments). Thus, assessment as a component of nursing practice consists of a combination of deliberation and enactment.

Dilemmas challenge researchers investigating concepts in the practice domain. For example, concepts are embedded in practice, indivisible, and difficult to isolate from the complexities of practice (e.g., "knowing the patient," differentiating some deliberation and enactment activities, cognitive processes, the impact of the practice setting, and suicide risk assessment). Additionally, practitioners do not function in isolation and practice is influenced by a multitude of factors (e.g., contextual, institutional, and transference phenomenon). These factors influence practice (including assessment) and can impact scientific exploration.

Nursing assessment is a key component of the practice domain. It involves a process of systematic collection and analysis of data about a client

for the purpose of making a judgment or nursing diagnosis (Gordon, 1994).

Assessment serves as a foundation for nursing care. As such, nursing assessment can be conceptualized and framed as a primarily deliberative (cognitive) process in nursing practice. Most, if not all, nurse scholars would concur that nursing assessment is ongoing and is an integral aspect of the enactment phase, as well as the deliberation phase of nursing practice.

As an essential element of practice, assessment is generally conceptualized as involving cognitive and behavioral actions that are interwoven with the agent of practice. The most fundamental example of such actions is called, "nursing process," a problem-solving framework which incorporates assessment, diagnoses, planning, implementation, and evaluation.

The nursing process (which is taught in nursing education) requires a deductive reasoning process which is not the inductive, problem-solving process (which originates from the nurse activating a hypothesis) in use during decision-making activities. Furthermore, the conceptualization of practice within the nursing process framework is linear and fails to account for the complexities inherent in the circular or iterative processes of nursing practice. Actual nursing practice involves higher functioning competencies such as critical analytical thinking and a repertoire of other complex behaviors, often subject to multiple interpretations (e.g., caring, advocacy, and "knowing" the client). Since nursing assessment is a critical component of the fundamental nursing process, nursing theorists incorporate assessment in their

conceptualizations. Mental health nurse theorists, although not specifically focusing on suicide risk assessment, include mental/physical assessment in their nursing process conceptualizations (Orlando, 1990; Peplau, 1952, 1997). Kim (2000) notes that most theorists regard the nursing process model as an accepted "principle" or "theory" and consider practice domain phenomena unsystematically and "tangentially, rather than as the primary foci for description and explanation" (p. 147). As Kim (2000) explicates, "The attitude that nursing action follows naturally from nursing assessment is particularly prominent in models which nursing action is viewed in a prescriptive manner" (p. 144) [e.g., Neuman, 1995; Roy & Roberts, 1981].

Other theorists, however, emphasize nursing assessment as a process involving more sophisticated diagnostic/clinical reasoning (e.g., Aspinall & Tanner, 1981; Carnevali & Thomas, 1993; Gordon, 1994). Carnevali and Thomas (1993), for example, address the complexities of nursing assessment as a process involving an integrative overlapping of data collection and analysis, informational processing, meaning assignment, and diagnostic labeling for use in actual clinical situations. Nursing process and related assessment involve numerous loops back through previous components and, hence, are not linear in actual practice. In this conceptualization, higher-level cognitive processes such as diagnostic reasoning are emphasized. Gordon (1994) also emphasizes the diagnostician's cognitive and perceptual assessment abilities and addresses the centrality of knowledge utilization in clinical practice. Tanner, Benner, Chesla, and Gordon (1993) advocate

holistic assessment and have studied complex related practice constructs such as tailoring ("knowing the patient") and intuition.

Assessment requires the cognitive processes of critical thinking and diagnostic reasoning in order to make nursing judgments. Clinical judgment involves data analysis and is the outcome of an inferential process. One cannot focus on all the data simultaneously. Thus, one learns to discriminate between patterns of stimuli to identify pertinent information and assign meanings to situations (Gordon, 1994; Carnevali & Thomas, 1993). To identify a problem, collect data on the problem, distinguish underlying premises, formulate hypotheses, and draw conclusions are all components of critical thinking, diagnostic reasoning, and assessment. As a precursor to recognizing and interpreting data that is significant to a client's situation, formulating judgments or decisions (critical thinking, for example), is related to accurate assessment. Thus, the greater the nurse's capacity to critically think, the more accurate the assessment should be (Wilson, 1998). This illustrates assessment from the rational approach that may not be what is occurring in actual practice.

Variability in nursing practice, along with individual nurses' philosophies, might account for qualitative differences in how nurses practice in relation to suicide assessment. For example, a nurse might *accurately* assess a client as acutely "suicidal" and, thus, diagnose the client as "high risk for suicide" undertaking all reasonable and customary precautionary standards of practice (including one on one continuous observation) while another nurse

might *inaccurately* assess the same client (under exact circumstances) as "provocative" and "acting-out" and, thus, neglect to take appropriate suicide precautions (an erroneous judgment with potential lethal consequences). Furthermore, although nursing diagnoses are routinely used in practice, Kim (1987) notes, nursing diagnoses are atheoretical, descriptive "averages," (p. 101) and seem to have a very little utility beyond the purposes of inter-professional communication and documentation.

Nurses must frequently function instantaneously and adopt varied assessment/decision making strategies such as information processing, diagnostic reasoning, critical thinking/processing, heuristics, optimization, intuition, cost-benefit analyses, and decision under conditions of uncertainty. Research has noted differences in novice and expert decision-making and practice (e.g., Benner, 1982, 2000; Benner, Tanner, & Chesla, 1987; Lauri et al., 2001) and investigated nurses' use of intuition in clinical practice (Benner & Tanner, 1987). Such variables could influence the assessment process and outcome since the problem here is how to accurately assess an often purely subjective/intersubjective phenomenon such as suicide.

In short, nursing assessment can be conceptualized as an ongoing process within the enactment and deliberation dimensions of the practice domain. Conceptualization of nursing practice including contemporary methods or standards of suicide assessment is continually evolving.

Conclusions

The aforementioned studies and approaches have been used to examine the phenomenon of suicide and suicide assessment. However, there is a lack of knowledge regarding what nurses do in their assessment of suicide in actual practice. Additionally, given that individual's perceive and conceptualize phenomena differently, variability in suicide assessment is likely to be a reality. This phenomenographic study was undertaken with the assumptions that nurses may not rely strictly on a rational process in assessing suicidality as in assessment in general, and that it is necessary to examine the processes as they occur in actual practice. It is hoped that research findings would add to the developing knowledge regarding the understanding of suicide assessment by nurses.

Furthermore, since it is unclear whether the rational approach to suicide assessment is used uniformly in practice, phenomenography is a useful method and theory which could provide (a) improved knowledge regarding the characteristics of nursing assessment of suicidality, (b) identification of differences in the assessment strategies for suicidality used by psychiatric-mental health nurses, (c) better knowledge regarding the understanding of suicide held by nurses in relation to suicide assessment, and (d) knowledge regarding how nurses perceive their education and/or experiences influencing (shaping) their suicide assessments.

CHAPTER III

METHODOLOGY

Research Questions

The purpose of this study was to identify and describe categories of descriptions regarding strategies used by psychiatric-mental health nurses in suicide assessment applying phenomenography as a method focusing on the following research questions:

1. What are the understandings (conceptualizations) of suicide held by nurses in relation to suicide assessment?
2. What are the strategies of suicide assessment used by psychiatric nurses?
3. How do the strategies of suicide assessment used by psychiatric-mental health nurses compare with current practice guidelines on suicide assessment?
4. How do nurses perceive education and/or experience influencing their suicide assessments?

The primary aims of this study were to gain an understanding of nurses' conceptions regarding suicide and suicide assessment, to describe the strategies of suicide assessment adopted by psychiatric-mental health nurses, contrast these to the contemporary standards and practice guidelines of suicide assessment, and explore participant perceptions regarding how education and/or experience influence their suicide assessments.

Design

The phenomenographic approach was applied in this research by putting the focus on discovering the nature and characteristics of suicide assessment and strategies used by psychiatric-mental health nurses, including similarities and qualitative differences. The focus was on the participants' thinking in the assessment of client's suicidality. The study attempted to discover—without any preconceived notions—the complexities involved in suicide assessment in the context of different ways (e.g., strategies) nurses approach the problem. Greater understanding of nurses' conceptions of suicide and strategies used in suicide assessment is important in advancing nursing practice, enhancing professional education, and improving client outcomes. A phenomenographic approach was appropriate in exploring these questions.

The research design was an inductive qualitative descriptive study with phenomenography as its orientation. The data were collected through participant observations of nurses assessing patients and semi-structured in-depth interviews with nurses regarding their assessments of actual cases and vignettes. The analytic processes suggested for a phenomenographic study were applied for data analysis. The nurse participants in a convenience/snowball sample were six psychiatric-mental health nurses practicing in two psychiatric settings in New England states: a) a psychiatric hospital's emergency assessment service and b) a locked inpatient psychiatric unit of a general hospital.

Phenomenographic Method

Relationship Between Phenomenography and Phenomenology

There often is a misunderstanding of phenomenography, as it is confused with phenomenology because of the similarity in the terms.

Phenomenology and phenomenography are related but distinct theoretical approaches relevant to the human and social sciences. Phenomenology evolved as a theoretical approach in psychology, whereas phenomenography was relatively recently proposed as a methodological approach in pedagogical research, specifically in educational psychology. As is evident from their names, both approaches relate to phenomena. Phenomenology and phenomenography may interface with each other inasmuch as learning is a process of human cognition.

The epistemological foundations are identical in both research traditions; i.e., there is no objective, real world out there. Rather, human knowledge is founded in their conceptions of reality (Sandberg, 1995). Both research traditions seek to reveal the nature of human experience and awareness in order to understand these conceptions of reality (Marton, 1997). Also, in both research traditions, the goal is to describe the conceptions, not explain the cause or function of these conceptions (Larsson, 1986). However, there are some basic differences within these two research traditions.

Historic Origins and Definitions

Phenomenology is a philosophical movement that began in the philosophical tradition of Edmund Husserl in Germany during the mid-1890s.

Early followers of Husserl's work described phenomenology as the study of *essences* of human phenomena, such as the essence of emotions. As was later formulated by Husserl, phenomenology is the study of the *structures of consciousness* that enable consciousness to refer to various objects existing outside itself. This type of study requires reflection on the content of the mind to the exclusion of everything else, such as: theory, deduction, or assumptions from other disciplines (e.g., natural sciences). Husserl referred to this type of reflection as *phenomenological reduction* or "*pure description*." Structures of consciousness that Husserl discovered were such acts as remembering, desiring, and perceiving and the abstract content of these acts, which he termed "*meanings*." Later, in "Cartesian Meditations" (1960), he defined phenomenology as the study of how these meanings are constructed in the course of experience.

The first scholar to have used the term phenomenography, instead of "phenomenology" was Ulrich Sönnemann (1954), who distinguished between Heidegger's and Jaspers' schools of psychopathological research. Sönnemann believed that Jaspers' phenomenology should be called *phenomenography* since it was "a descriptive recording of immediate subjective experience as reported" (p. 344).

Phenomenography is a qualitative inductive research approach that was advanced in the 1970's in the Department of Education of the University of Göteborg in Sweden (Marton, 1988a; 1988b; 1970). Marton emphasized that phenomenography is *not* an offspring of phenomenology. The term

Phenomenography" has its etymological roots in Greek "phainomenon" (appearance) and "graphein" (description) making the literal meaning of the word, "a description of appearances." Phenomenography investigates *the qualitatively different ways in which people perceive, experience, conceptualize, and understand various aspects of phenomena*. This definition implies that the focus of phenomenography is on the *conceptions* of humans and how they perceive and conceptualize rather than the actual phenomena themselves. From a phenomenographic perspective, researchers attempt to "map," i.e., to characterize, how phenomena are perceived by people of different ages, historical periods, cultures, subcultures, etc. As Marton (1988b) states, "Phenomenographers do not make statements about *the world as such*, but about people's *conceptions of the world*" (p. 145, emphasis added). Thus, phenomenographers are not necessarily interested in whether such conceptions are true or false but rather in why and how these conceptions are formed. Marton (1981) describes this as the "second order" perspective. For example, instead of asking, "Why do some children succeed in school better than others?" (first order approach), the phenomenographer's inquiry would be "Why do people think that some children succeed in school better than others?" Or, instead of asking "Why are some people at risk for suicide?" the phenomenographer may ask "How do nurses determine that some people are at risk for suicide?"

Strengths and Weaknesses

The major advances in phenomenography have been in pedagogical research, and, to a limited extent, other disciplines. The approach is still relatively new (25-30 years). It has been primarily developed in Sweden and has not yet received wide recognition.

The most important question with regard to the empirical data of any scientific inquiry is its validity and reliability. In quantitative studies, validity and reliability are often reflective of instrument accuracy and reproducibility of results. In qualitative research, where instrument accuracy is often absent or difficult to assess, it is commonly looked at from the perspective of credibility. Since the phenomenographic approach addressed the "second-order perspective" (i.e., the object of the study is the subjective thinking of the participant), what the participants' say and how they say it are givens. The "truth" is what the participants say and how they say it. Marton (1988) claims that replicability in phenomenography is not possible or even desirable. "The original finding of the categories of description is in a form of discovery, and discoveries do not have to be replicable. On the other hand, once the categories have been found, it must be possible to reach a high degree of *intersubjective agreement* concerning their presence or absence if other researchers are to be able to use them" (Marton, 1988, p.148). Thus, reproducibility is substituted by *intersubjective agreement among researchers*, which is deemed to be "sufficient" when 65 to 100% of researchers agree.

Another issue is rooted in the fact that the data are collected through interviews. This fact necessarily limits the numbers of participants and raises the question whether results obtained from a small number of participants are representative of a larger group. This may limit generalizability (transferability) of obtained results.

Phenomenography does not provide an exact algorithm for identifying the categories of description, nor does it provide a formal method for verifying validity of descriptions once they have been identified. Some might also argue that phenomenographic findings do not have significant value because phenomenographic research is concerned with answering questions of what and how and not why.

One way of looking at various research methodologies is to align them with the nature of the research problem for which a particular methodology is the most appropriate. As described above, the object of a phenomenographic study is not the phenomenon itself, but the content of human conceptions about that phenomenon. Consequently, the results extracted from the data collected in a phenomenographic study "do not necessarily contribute to an increase in the knowledge about the phenomenon [itself]" (Marton, 1981, p. 243). Where the focus of study is on a human or social phenomenon directly, that is, if the inquiry is "What is the essence of the phenomenon?" the phenomenographic method would not be appropriate. For instance, one may study the phenomenon of pain *per se* addressing such issues as what the phenomenon of pain is, how pain could possibly be measured, what causes it,

or how such pain can be best reduced or managed. In this case, the phenomenographic approach would not be very useful. If on the other hand, the researcher is interested in how pain is experienced and communicated by clients or how various medical professionals assess clients' pain, a phenomenographic approach could be utilized. To generalize, the phenomenographic approach is applicable when the researcher conducts a "second order" versus "first order" inquiry (Marton, 1981; Marton & Booth, 1997). What this means is that the research explores the ways in which individuals experience the phenomena and not the phenomena itself. Thus, it is unimportant if the participants' conceptions are "correct" or "incorrect," rather the research is aimed at identifying categories of description that provide the types and range of these conceptions.

This type of research is not uncommon in education or other kinds of systematic communication research (e.g., social psychology, advertising and marketing, etc.—although such research may not be labeled as phenomenographic) and is aimed at understanding people's ways of thinking and, ultimately, influencing these ways of thinking (and consequently, ways of acting). Such findings could have important implications to nursing education and practice.

Qualitative research focuses on the intensity, distribution of, and interdependence between qualities that cannot be quantitatively measured. This type of research seeks to discover whether a particular quality is simply present or absent, and if it is present, to provide a descriptive and explanatory

analysis of this quality. Accordingly, the aim of qualitative research is to provide categories of description that facilitate explanation of certain qualities (Dahlgren & Fallsberg, 1991). In contrast, quantitative research uses pre-defined (i.e., *a priori*) categories and seeks to discover quantifiable differences among variables.

The ultimate goal of phenomenographic research is to describe and categorize existing conceptions and, more generally, "to discover the structural framework with which various categories of understanding exist" (Morton, 1988, p.147). This implies that the basic assumption in any phenomenographic research is that "people vary with regard to what meanings they ascribe to phenomena in the world around them. Without such an assumption there would not be a need for any phenomenographic research whatsoever" (Dahlgren & Fallsberg, 1991, p. 151). According to Marton (1988), the most important research finding of phenomenographic research is categories of description themselves. In other words, the product of a phenomenographic study is the *description of categories of description*.

Marton compares phenomenography to a botanic study of previously unknown flora and fauna on a remote island. "In such a study, existing categories (species) are of limited usefulness. The botanists find new species and, therefore, must construct new categories. Only then can the botanist determine how these new categories fit into the whole system of species classification. ... Just as the botanist finds and classifies previously undiscovered species of plants, the phenomenographer must discover and

classify previously unspecified ways in which people think about certain aspects of reality" (Marton, 1988, pp. 147-148). If this example is elaborated further, it could illustrate the importance of phenomenography as qualitative research. Indeed, it took significant groundwork of discovering and describing various species before Darwin came up with his theory of evolution ("survival of the fittest") that was constructed upon such phylogenetic findings. The result of a phenomenographic study consists of finding and defining the existing subjective categories of meaning expressed in collected data (observations, thematic, or semi-structured interviews) according to how they can be grouped.

Marton (1988) describes two major lines of phenomenographic research that have been conducted. The first concerns general aspects of learning, seeking to understand the learning process, in general. For example, Pramling (1983) studied children's conception of learning and found that it is related to their discovery (or failure to discover) that there is a difference between 'wanting to do' versus 'being able to do' and that this difference is related to practice and exercise. The related, second line of phenomenographic research has dealt with how people conceive various aspects of reality. In, so-called, "content domain learning" studies, researchers have tried to map students' preconceived ideas about specific phenomena or concepts related to specific disciplines, for example, electricity, gravity, algebraic operations, etc. Researchers have investigated whether students' conceptions become modified through formal instruction and how

this occurs. Researchers have also investigated people's general understandings of various concepts such as inflation, political power, taxes, etc. Studies such as this are referred to as "pure" phenomenography.

Although the earlier studies in phenomenography were conducted in education (pedagogy), later applications of phenomenography extended to other disciplines. The phenomenographic approach has also been utilized in client-care studies where important qualities of the subject of inquiry were discoverable primarily in systematic client-caregiver communications. In short, the phenomenographic approach has been used to discover different ways of how phenomena that relate to a perspective on health, illness, and treatment were perceived by the care giver or experienced by the client rather than what the phenomena actually were. Below are examples.

Dahlgren and Fallsberg (1991) in a social pharmacy study used phenomenography to investigate medication compliance. Because a major source of non-compliance was found to be experienced or anticipated side effects, through a phenomenographic inquiry the researchers addressed how clients conceived the concept of side effects.

Sjöström (1998) researched post-operative pain assessment strategies and the quality of such assessment in relation to clinical experience and professional role of caregivers. Interestingly in his study, the quality of the assessment was determined by the concordance between client's and staff members' ratings. The researcher's interest was directed towards the participant's thinking in terms of the assessment of the clients' pain. Data

were collected in semi-structured interviews. The researcher identified the following four categories of description related to the conception of pain assessment:

- a. "I have learnt a typology of patients." (Typology)
- b. "I have learnt to listen to the patients." (Listening)
- c. "I have learnt what to look for." (Looking)
- d. "I have learnt what to do for the patient." (Doing) (p. 116).

The distribution of these categories was then compared between nurses and physicians and analyzed with regard to the quality of assessment data. Because pain assessment is a *routine* nursing task, the author hypothesized that the quality of assessment is influenced by experience. In order to analyze the influence of experience, both groups were subdivided according to the length of experience (expert and novice). This study illustrates how a phenomenographic inquiry may provide a basis for description and/or explanation of observed differences.

Data Analysis in Phenomenography

Dahlgren and Fallsberg (1991) provide the following metaphor and procedure for the process of data analysis in a phenomenographic study.

"Imagine that somebody is given an ordinary pack of playing cards and asked to sort them. Most probably the result would be four different groups of cards according to the four suits. A possibility is of course thirteen groups according to denomination. ...but the important difference with card sorting task is that the researcher does not previously know the categories according to which the

task can be solved" (p. 152). Methodologically, the research most commonly proceeds in the following sequence: *familiarization* → *condensation* → *comparison* → *grouping* → *articulating* → *labeling* → *contrasting*. Each of these stages is explained below.

a. *Familiarization*. The researcher, although in most cases also the interviewer, must read through the protocols carefully, to get acquainted with them in detail. This stage is also necessary for making required completions and corrections.

b. *Condensation*. The most significant statements made by the participant are selected to give a short but representative version of the entire dialogue concerning a certain phenomenon.

c. *Comparison*. The selected significant dialogue excerpts are compared in order to find sources of variation or agreement.

d. *Grouping*. Answers, which appear to be similar, are put together.

e. *Articulating*. A preliminary attempt is made to describe the essence of the similarity within each group of answers. Stages four and five may be repeated several times.

f. *Labeling*. The various categories are denoted by constructing a suitable linguistic expression.

g. *Contrasting*. The obtained categories are compared with regard to similarities and differences (Dalhgren, 1991, p. 152).

In summary, phenomenography is an appropriate methodological approach to study suicide assessment by nurses.

Data Collection and Analysis

Study Participants

The recruitment of psychiatric-mental health nurse participants was accomplished using a convenience/snowball sampling. The nurse participants in this sample were six psychiatric-mental health nurses (conversational partners) practicing in two psychiatric settings in two different states in northeast New England: a) a psychiatric hospital's emergency assessment service and b) a locked inpatient psychiatric unit of a general hospital. Since there was only one male participant, all participants have been given a female pseudonym in order to protect individual identity. Five of the participants had more than fifteen years of experience as psychiatric-mental health nurses, while only one had less than one year experience as a psychiatric-mental health nurse yet this participant worked as a mental health worker for five years prior to becoming a registered nurse.

Human Subjects

Approval from the Institutional Review Boards on Human Subjects at the University and two participating hospitals were obtained in July 1, 2002, July 15 2002, and January 6, 2003. The consent forms for this research approved by these Boards were used prior to the data collection phase.

As part of the informed consent procedure, participants were informed that the information they provided would be used for research purposes and communicated in oral and written reports. Participation in this study was voluntary. Due to the sensitive nature of the study, consent forms and

identifying face sheets have been kept separate from the rest of the data for the study and secured in locked boxes at the researcher's office as outlined in the consent forms. The listing of the names and assigned code numbers were recorded on a separate sheet filed in a locked drawer to which only the investigator has access. All records, including notes and transcribed interviews, do not identify participants by name and are kept locked in a file cabinet. A code number identifies the interview. Audiotapes have been kept in a separate locked file cabinet. Participant's names do not appear on the audiotape label. A number, assigned by the researcher, which appears on the tape label, identifies participants. Because the audiotapes have intrinsic value as an audit trail and for future research, they will be kept in a locked cabinet for three years then permanently destroyed by this researcher.

Adult patients who were being assessed by the study participants for suicidality were approached for their consent for this researchers observation during the assessment sessions. Inclusion criteria for consenting adult patients were that they were 18 years of age or older, could speak English, and were competent to provide informed consent for observations (i.e., individuals with guardians or who were court mandated were excluded). Patient consent forms do not identify the patient as seeking psychiatric services. These forms have been kept locked in a separate file cabinet in another location and will remain so for three years then destroyed by this researcher.

The study records have been shared with only a small number of professional colleagues (specifically, this researcher's Major Professor and second reader on the Dissertation Committee). At the end of the research, all written notes and cassettes will remain secured in locked cabinets and destroyed after three years.

Data Collection

The data were collected through participant observations and audio taped in-depth semi-structured interviews. Each participant was observed by the researcher performing a suicide assessment. After the assessment of an actual case was completed, a semi structured audio taped interview was conducted. Each participant was later asked to read three vignettes of cases depicting different degrees of suicidality. The vignettes were administered in a standardized manner. In-depth semi structured interviews were conducted using the same format as with the actual (observed) case. Additionally, each participant was asked to rate the three vignettes according to level of suicide risk (low, moderate, or high).

The data collection was conducted in four phases over approximately ten months (July 2, 2002 – August 16, 2003). Prior to initiating Phase I of this study, three vignettes depicting three different levels of suicidal risk were obtained for use in suicide assessment (Appendix D). The use of vignettes in addition to an assessment of an actual client was determined because of the difficulty anticipated in obtaining clients with potential suicidal risks in practice situations.

The focus in Phase I was gaining entry and obtaining informed consent (Appendix E) and demographic data (Appendix F) from nurse participants. Snowballing technique was used to identify nurse participants. Once identified, this researcher contacted potential participants at a convenient time. The researcher reviewed the four phases of the study and guaranteed confidentiality. Once all questions were satisfactorily and fully answered, the researcher obtained signed and dated informed consent. A copy of the consent was promptly given to the nurse participant.

In Phase II, prior to observations, the consenting nurse participants asked potential appropriate adult patients' permission for this researcher to observe the assigned nurse interview them. Each eligible patient was informed that the researcher was a nurse studying nurses in practice by observing them interview patients. Patients were informed that their decision (to participate or not) would not affect their care. The assigned nurse or this researcher obtained written consent (Appendix E). Opportunities for any questions to be fully answered by this researcher were provided. If there was any disruption in agency routine (at any time), the plan was that this researcher would remove himself; This did not occur. Pending patient informed consent, the researcher began with the first nurse-participant by observing the nurse perform a suicide assessment on a consenting adult patient. This process was repeated with subsequent nurse participants.

During the observational periods, the researcher was located on the periphery, observing the nurse-participant as she or he assessed the patient.

As immediately as possible following each observation session, the researcher arranged a formal interview with each participant using a post-assessment guide that contained specific questions (Appendix G). The formal interviews were conducted in a private area away from others to maintain confidentiality, freedom of speech, and provide a conducive environment. The focus was to gain each nurse's description of their assessments. The goal was to have each nurse participant (a) articulate their understandings (conceptualizations) of suicide, (b) discuss strategies adopted during the client assessment, (c) describe whether or not the participant used clinical practice guidelines, and (d) discuss the participant's perceptions regarding the impact, if any, of education and clinical experience on their suicide assessments. These interviews, lasting about one to one and a half hours each were audio taped for later transcription by this researcher and iterative analysis using phenomenographic procedures.

In Phase III, each nurse (at a convenient time) was asked to read three uniform vignettes of varying levels of suicide risk and estimate their levels of risk for suicide. Each nurse was then asked to verbally respond to the three vignettes (Appendix D) based on semi-structured interview questions (Appendix G). These interviews with each participant lasting about one hour per vignette were also audio taped for later transcription by this researcher and iterative analysis.

Phases II and III lasted approximately ten months (July 2, 2002 – April 16, 2003). Ongoing iterative data analysis using phenomenographic

procedures occurred and concluded with the final analysis phase (Phase IV) and write up of the study.

In Phase IV, ongoing transcription, final data analysis and write up continued. To validate the data analysis findings, two doctorally prepared nurse researcher/experts/academicians provided 100% inter-rater agreement (i.e., agreement of identified phenomenographic categories of description). Phase IV was completed with the write up of the report (February 7, 2004).

Diversity in Research

The researcher attempted to invite nurses representing diverse ethnicity, race, or gender who met the inclusion criteria. It was not feasible to obtain this representation because of the sample size.

As with the nurse participants, consenting adult clients of any ethnicity, race, or gender who met the inclusion criteria (as stated in the informed consent form) were invited to participate. An attempt to obtain a diverse patient population was reasonably made, however, given the design and sample size, it was not feasible to represent an array of minority patients.

Data Analysis

Responses from each participant were transcribed verbatim by this researcher. Each participant's verbatim transcription was analyzed using the seven steps in the phenomenographic research tradition. The data analysis sequence occurred as follows: familiarization → condensation → comparison → grouping → articulating → labeling → contrasting (Dalhgren & Fallsberg,

1991, p. 152). The detailed results obtained following this process are presented in Chapter IV.

The final write up was completed after terminating the data collection phase and final analysis of the data.

Trustworthiness

After exiting the research setting, the ongoing transcription process and final data analysis continued. To validate the data analysis findings, two doctorally prepared nurse researcher/experts/academicians provided 100 % inter-rater agreement (i.e., agreement of identified categories of description [Marton, 1988]). A variety of checks and balances were used such as communicating with appropriate colleagues and iterative dialogue with them to obtain critical feedback and ensure rigorous adherence to the methodological process of phenomenography and credibility of the findings.

Inter-rater reliability of the three vignettes was obtained by unanimous consensus of five advanced practice psychiatric nurses (master's and doctorally prepared). Further assurance of quality in using the phenomenographic method was accomplished by making the research process visible and allowing for systematic reviews by members of the dissertation committee. Additionally, diligently adhering to the interview guide across participant interviews, administering the vignettes in a standardized manner, obtaining descriptive detail (fittingness), and strict adherence to the phenomenographic sequential steps of data collection and analyses (auditability) further validated trustworthiness (Bowden & Walsh, 2000).

CHAPTER IV

RESULTS

Identified Categories of Description

The following section provides the results of the analysis in relation to the research questions.

A. Familiarization. This researcher transcribed the audio taped responses of participants within 8-12 hours of each conversational interview. Once the audiotapes were transcribed, familiarization of the data was accomplished by rereading of the transcripts several times and repeatedly listening to the audio tapes. The complete transcripts of the interviews were reviewed by two members of the dissertation committee in their entirety, and are being kept for future audits.

B. Condensation. Following the familiarization process, the most significant statements made by the participant(s) were selected to give a short representative version of the complete dialogue concerning the phenomenon of suicide assessment (e.g., "I assess for depression."). The researcher kept detailed notes of his experiences in collecting and analyzing the data, and the feedback and responses received from the major professor and a member of the dissertation committee regarding the research process, data analysis, and write-up of the dissertation. Based on this essential feedback, appropriate adjustments were made and preliminary categories were more clearly and logically identified. An initial identification of 16 preliminary (P) categories (Appendix H) was made and shared with this researcher's major professor and

second reader for their analytic and clinical expertise and to ensure methodological rigor and validity. With the expert guidance of the major professor and second reader, it was discovered that several of the preliminary (P) categories were overlapping and more appropriately and logically subsumed under another category (e.g., FEASIBILITY OF A PLAN [P06] was included in ASK ABOUT A PLAN [P05]). These categories were then further collapsed. As a result of this process, the initial 16 preliminary categories were condensed to ten categories (Appendix I). These ten categories of description were:

- Reliance on risk factors which are well-established in the literature (C01) (e.g., relying on the evidence of depression and substance abuse).
- Looking for the presence of states commonly associated with suicidality (C02) (e.g., investigating to see whether the client exhibited psychosis and increased agitation followed by calmness).
- Presence and availability of resources (C03) (e.g., looking into the presence or absence of responsible family, significant other(s), other social support(s), and out-patient provider(s)).
- Listen to client (C04) (e.g., listening to the client as he/she talked about past and/or present status, problems, or issues of concern).

- Ask about a suicide plan and/or the feasibility of carrying out a plan (C05) (e.g., directly asking the client as to whether he/she has any suicidal intention, plan, and access to a plan).
- Reliance on exemplars (C06) (e.g., relying on past experiences with clients who represent exemplary cases or on “classic, textbook” examples).
- Reliance on intuition (C07) (e.g., relying on the “gut” sense).
- Perceptions of significant others (C08) (e.g., meeting with a friend or family to assess their perceptions on the client’s current situation and validate data obtained from clients who are often distracted and inaccurate).
- Reliance on other professionals (C09) (e.g., using assessments done by other professionals through consultation and communication with them).
- Related stories of suicide risk (C10) (e.g., relying on the presence of relevant personal stories such as interpersonal loss, loss of health status, or loss of employment).

C. Comparison. Following the condensation phase, significant dialogue excerpts were compared, in order to identify sources of variation or agreement. The audiotapes and transcriptions were repeatedly reviewed again to identify verbatim excerpts from the participants.

For organization, a grid was made listing each of the ten categories in a column with the actual case and three vignettes in corresponding rows. This

process led to the identification of those participants that used or did not use each of the ten categories for the actual case and the three vignettes (Appendix J).

Next, significant dialogue excerpts were compared to identify potential sources of variation or agreement. Verbatim examples provided evidence as to whether participants used or did not use the categories and the initial grid was further developed (Appendix K).

D. Grouping. Following the comparison phase, participants' answers (responses) that appeared to be similar were grouped together.

E. Articulating. Following the grouping phase, a preliminary attempt was made to describe the essence of the similarity within each group of verbatim answers. Stages four and five were repeated several times to confirm the logic and accuracy of the analysis.

F. Labeling. Following the articulating phase, the categories of description that emerged were denoted by constructing an appropriate linguistic expression. These linguistic expressions more parsimoniously identified discovered categories of description (Appendix L). These were labeled as:

- RISK FACTORS (C01)
- ASSOCIATED STATES (C02)
- RESOURCES (C03)
- LISTEN (C04)
- PLAN/FEASIBILITY (C05)

- EXEMPLARS (C06)
- INTUITION (C07)
- SIGNIFICANT OTHERS (C08)
- OTHER PROFESSIONALS (C09)
- RELATED STORIES (C10)

G. Contrasting. Following the labeling phase, the obtained categories were compared with regard to similarities and qualitative differences (Dalhgren & Fallsberg, 1991, p. 152). Of the 10 categories of descriptions that emerged, 4 qualitative differences among the participants were identified, namely:

(a) reliance on exemplars/experiences of similar cases

(EXEMPLARS);

(b) reliance on intuition/gut sense (INTUITION);

(c) reliance on the assessments of other professionals (OTHER PROFESSIONALS); and

(d) reliance on related stories (RELATED STORIES).

Participants' Perceived Conceptualizations of Suicide Assessment

(Research Question #1)

For research question #1 (i.e., What are the understandings (conceptualizations) of suicide held by nurses in relation to suicide assessment?), the conceptualizations of suicide discovered in the interviews with the participants are as follows:

First Participant–Amy

Amy is a masters-prepared, certified psychiatric clinical nurse specialist, with 25 years of psychiatric nursing experience, 17 years in acute inpatient units and eight years in psychiatric assessment service at the same urban psychiatric teaching hospital. Her current role is in the psychiatric hospital's emergency assessment service involving emergency assessment of acutely ill diverse psychiatric clientele.

Amy conceptualized suicide as a risk for wanting to kill oneself because of feelings of hopelessness (negative outlook on life), inadequacy, and worthlessness, and having nothing to live for. She identified depression as the "trigger" (precipitant) and emphasized the vital role of the presence of (viable) resources to the distraught individual as critical components of suicide assessment.

Second Participant–Beth

Beth is a masters-prepared (non-nursing), certified psychiatric nurse generalist enrolled in an MSN program with 26 years psychiatric nursing experience, five years on a psychiatric inpatient unit, 10 years in psychiatric emergency services, and 11 years in psychiatric community/psychiatric day hospital at the same urban psychiatric teaching hospital. Her current role is in the psychiatric hospital's day program involving emergency assessment of acutely ill diverse psychiatric clientele.

Beth conceptualized suicide as self-inflicted death because the individual felt there was nothing to live for. She focused on the

thought (ideation) accompanying the (suicidal) condition. Beth also identified depression as a precipitant and emphasized the vital role of investigating the individual's attempts and plan as critical components of suicide assessment.

Third Participant—Carol

Carol is a bachelor's prepared psychiatric nurse with 15 years psychiatric nursing experience, five years in psychiatric inpatient units and 10 years in a psychiatric assessment service in the same urban psychiatric teaching hospital. Her current role is in the psychiatric hospital's psychiatric assessment service involving emergency assessment of acutely ill diverse psychiatric clientele.

Carol conceptualized suicide as an individual's perception that there is no alternative but to end life with accompanying feelings of rejection, worthlessness, and sadness coexisting with depression.

Beth identified these factors as essential components of suicide assessment.

Fourth Participant—Denise

Denise is an associate degree-prepared psychiatric nurse with a previously earned Bachelor of Arts degree in psychology who worked for five years as a mental health worker at another facility, a small rural psychiatric teaching hospital. Denise currently has nine months of psychiatric nursing experience following general visiting nurse experience. All of her psychiatric

nursing experience has been as a staff nurse on a psychiatric inpatient unit in a suburban general community hospital.

Denise conceptualized suicide as self-induced death. She attributes suicidality to feelings of helplessness, hopelessness, impulsivity, anxiety, and anger accompanied by depression and self-destructive behaviors. Denise identified loss as a precipitant, and substance abuse, a history of past attempts, family history of suicide, and male gender as risk factors. She emphasized the vital role of social support (e.g., family and friends). Denise also focused on withdrawal, isolation, having a specific plan with access, and the energy required to commit suicide. She identified these as essential components of suicide assessment.

Fifth Participant—Eve

Eve is a three year diploma nurse who later earned a bachelor's degree in nursing and is certified as a psychiatric nurse generalist. She has had 25 years of nursing experience with 19 years as a psychiatric nurse. She was a staff nurse on an inpatient unit in a suburban psychiatric hospital for 18 years and a psychiatric nurse in a partial day hospital for one year. Currently she works as a staff nurse on a psychiatric inpatient unit in a suburban general community hospital.

Eve conceptualized suicide as a desperate act to end one's life due to the individual's perception that there is no other way of

eliminating their pain and suffering. She attributed suicidality to the inability of an individual to look forward to his/her life. Eve also looked for anger, desperation, and depression in the patient's presentation. Eve identified these as essential components of suicide assessment.

Sixth Participant—Fran

Fran is an associate's degree psychiatric nurse with 28 years of nursing experience including 23 years in psychiatric nursing, 14 years on an inpatient psychiatric units and eight years in psychiatric assessment service, all in the same urban psychiatric teaching hospital. Previously, Fran also worked four months as a psychiatric visiting (community) nurse. Her current role is as a staff nurse in the hospital's psychiatric assessment service involving emergency assessment of acutely ill diverse psychiatric clientele.

Fran conceptualized suicide as an act to end one's life because the individual feels totally hopeless and helpless; is not able to change life's circumstances; is unable to live with the intense and overwhelming emotional suffering; and believes that he/she is better off dead. Fran conceptualized suicide assessment as a "judgment call." She identified specific precipitants and risk factors as past attempts, no future orientation, decreased level of functioning, and the presence of (recent) losses. Fran identified these as essential components of suicide assessment.

Interestingly, yet not surprisingly, given the psychiatric practice settings of participants, all participants' conceptualizations of suicidality related

exclusively to the taking of one's own life during emotional distress (i.e., there was no mention of other modes of suicide such as euthanasia, terrorist suicide, group/suicide packs, etc.).

Summary

Overall, based on participants' conceptualizations of suicide, one may conclude that these psychiatric nurse participants conceptualized suicide as an attempt to end one's life when pain is intolerable. This is consistent with Shneidman's theory. Additionally, these participants believed that suicide is associated with hopelessness, helplessness and is primarily linked to depression. This also is consistent with Shneidman's and Beck's theories. These nurses did not conceptualize suicide as an impulsive act that could come without warning. Instead, they viewed suicide as a possible act that results from clients' persistent conditions of life and psychological states of hopelessness.

Participants' Strategies for Suicide Assessment

(Research Question #2)

For research questions #2 (i.e., What are the strategies of a suicide assessment used by psychiatric nurses?), the following provides a description of the strategies used by participants in suicide assessments.

First Participant–Amy

Assessment of an Actual Case. Amy assessed a 44 year old single Caucasian female who came voluntarily, accompanied by a friend, to

emergency services in an urban psychiatric hospital for an evaluation of her alcohol and polysubstance abuse relapse. This client expressed passive suicidal ideation with increased self-destructive behaviors. The stated precipitant was the September 11 terrorist attacks. During the assessment session, Amy sat at a desk facing the client who sat to Amy's left. Using the hospital's psychiatric assessment service form, Amy spent about 45 minutes asking questions regarding the client's past psychiatric history, past suicide attempts, current thoughts of wanting to hurt herself, ability to "contract for safety," employment status, financial issues, current abuse of alcohol and/or polysubstance abuse, precipitants to her current crisis, the presence of auditory and/or visual hallucinations, paranoia, judgment and insight. In addition, the client was assessed for depression.

Amy rated the client's suicide risk as, "low." In the post assessment interview Amy stated she used the following strategies to determine the client's level of risk: (a) directly asking the client about suicidality, (b) direct observation of the client's presentation/behaviors, (c) using risk factors, (d) evaluating the friend's perception, (e) mental status assessment findings (e.g., insight, judgment, and lack of psychosis), and (e) consultation with another professional. Of the 10 strategies that emerged as those adopted by the nurses in the study, Amy did not use RELIANCE ON EXEMPLARS and INTUITION.

Assessment of the Vignettes. Regarding the emerged categories of description in relation to the three vignettes, only in the actual case did Amy

rely on the collaborative judgment of other professionals. She did not verbalize this in any of the vignettes. Amy rated the vignettes regarding the degree of suicidality as follows: vignette #1: moderate risk; vignette #2: high risk; and vignette #3: low risk.

Second Participant—Beth

Assessment of an Actual Case. Beth assessed a divorced Caucasian female, about 40 years of age, who came voluntarily for a psychiatric evaluation to determine the level of care that she needed at the time (i.e., partial hospitalization versus inpatient hospitalization). She came at the insistence of her out-patient therapist and her employer. The client admitted having experienced passive suicidal ideation and stated that if she did not have the sole responsibility for her child, she would commit suicide. Sitting diagonally across from the client and without the use of any forms or note taking, Beth spent about 20 minutes performing this psychiatric assessment asking questions regarding suicidal ideation, plan or intent, history of previous suicide attempts, family history, symptoms of depression, and risk profile (e.g., support, age, etc.). At the completion of her evaluation, Beth determined this client to be at “minimal risk” for suicide. She attributed her client’s passive suicidality to depression. At the post-assessment interview, Beth indicated using the following strategies in her assessment of this patient: (a) directly asking if the client had thoughts of hurting/cutting herself, (b) evaluation of out-patient professional and other support systems, (c) using risk factors, (d) inquiring about follow-up psychiatric appointments, and (e) use of intuition.

Assessment of the Vignettes. Regarding the emerged categories of description in relation to the three vignettes, in the assessment of vignette #1, Beth also used RELIANCE ON EXEMPLARS and, in the assessment of vignette #3, she also used PERCEPTIONS OF OTHERS.

In all instances, Beth did not rely on OTHER PROFESSIONALS as a strategy. Beth rated the vignettes as follows: vignette #1: high risk; vignette #2: moderate risk; and vignette #3: low risk. She was most adamant about not recommending inpatient hospitalization for the adolescent in vignette #3. This was based on her belief that hospitalization would result in regression and "learning more bad habits" for the client.

Third Participant—Carol

Assessment of an Actual Case. The client Carol assessed was an approximately 45 year-old Portuguese man who was being transferred to a psychiatric emergency room via ambulance from an acute care hospital following a suicide attempt with an overdose of multiple prescribed medications. During the assessment session, Carol sat at a desk facing the client who sat in front of her. Using the hospital's psychiatric assessment form, Carol spent about 30 minutes completing her assessment, asking questions regarding the events preceding his suicide attempt, previous psychiatric history, outpatient supports, presence of psychosis, current medications, his estranged relationship with his daughter, legal issues related to his upcoming divorce, cultural concerns, specific mental status assessment (i.e., thought process, thought content, impulsivity, and insight), the effects of

his work-related disability, medical history, current stressors, and his relationship with his girlfriend. Carol assessed this client to be at "medium to high risk."

Carol was astute in identifying subtle acute medical issues with her client and, although all participants were knowledgeable and skillful, Carol discussed numerous issues with exceptional depth and breadth (e.g., how "therapeutic use of self" and transference impact her nursing care). During the post-assessment interview, Carol indicated using the following strategies while performing her assessment of this patient: (a) directly asking if the client had suicidal thoughts, (b) asking if the client could identify precipitants to his overdose/suicide attempt, (c) "carefully listening" to the client "to understand what he was thinking when he had taken the pills ..." and his "current stressor," (d) evaluating the client's medical status, (e) assessing the availability of out-patient professional and other support systems, (f) using risk factors (g) investigating follow-up psychiatric appointments, (h) mental status assessment, and (i) asking "questions in a couple of different angles" in order to obtain greater accuracy in her assessment.

Assessment of the Vignettes. The strategies used for assessment of the three vignettes were similar to those used in the actual case. However, Carol did not use INTUITION and EXEMPLARS, with the exception of vignette #1. Also, Carol did not articulate LISTENING or reliance on SIGNIFICANT OTHERS with vignette #2.

Carol rated the vignettes as follows: vignette #1: medium to high risk; vignette #2: high risk; and vignette #3: high risk. Carol stated she felt confident in her level of certainty regarding her ratings of the suicide risks.

Fourth Participant—Denise

Assessment of an Actual Case. The client Denise assessed was a single Caucasian female in her 20's with an extensive psychiatric history including depression, past suicide attempts, and borderline personality disorder. The client was toward the end of her inpatient treatment on a locked psychiatric unit and completing a course of electroconvulsive therapy. Although Denise had never directly worked with this client, she was struck (as was this researcher) with the extent of the client's past self mutilation. There were deep lacerations throughout her forearms. Denise described the client as, "Sicker than she appears superficially ... quite high functioning ... a good patient ... and doing well from an outside perspective. But when you delve into her closer, she's really quite ill."

During the assessment session Denise sat opposite the client and did not use any hospital assessment forms nor did she take any notes. On the inpatient unit, the nurses performed "brief check-ins" which is often routine practice in settings where some client history is already known to staff (e.g., time limited, symptom focused assessment periodically done throughout a client's inpatient treatment and when a client is scheduled for a "therapeutic pass" off the unit to assess the client's ability to adhere to the purpose of the "pass" and accompanying viable expectations). Denise spent about 15

minutes performing a "brief check in" versus a comprehensive mental status assessment, asking questions regarding (a) suicidal ideation, (b) the client's "ability to contract for safety," (c) the client's ability to approach staff if she experienced recurrent suicidal ideation, and (d) the client's self rating of her depression.

During the post assessment questioning, Denise emphasized if she had more time to assess the client (other than her current "brief check-in") or if the client was a new admission (versus a client who had been on the inpatient unit for a considerable period of time), she would have reviewed the client's chart regarding background information, substance abuse issues, and family history of suicide. Denise stated that the unit had "developed" a "Suicide Lethality Scale" as part of the nursing assessment form but she did not use it during "brief check-ins" with clients nor felt it was especially useful as this scale was used on initial assessment and all clients were, generally, "over rated" by admitting nurses. Furthermore, this scale has not been tested for its reliability or validity. However, if Denise were to have used this scale, it would have captured the additional information that Denise would have assigned her client: anxiety, impulsivity, destructive coping, degree of withdrawal and isolation, and vague fleeting suicidal thoughts (Although the client denied suicidal ideation during the assessment, Denise added she would assign this to the client "erring on the side of safety").

At the post assessment interview Denise indicated that she relied on the following strategies: (a) directly asking the client about suicidality relying

on "her words" (e.g., "I believed her."), (b) observing the client's presentation"/behaviors, and (c) considering the client's self-report of her depression.

Denise rated this client's risk for suicide as "considerable ... moderate" yet "dangerous" for future suicide attempts and/or self-mutilative (parasuicidal) behaviors. Denise felt her certainty regarding the accuracy of her suicide risk assessment on this client was "50/50." Denise expressed her belief that there should be more reliable and valid suicide assessment tools (instruments) which would increase her confidence in the accuracy of her assessment.

Assessment of the Vignettes. Regarding the emerged categories of description in relation to the three vignettes, Denise did not use SIGNIFICANT OTHERS or RELATED STORIES in the observed interview or with the 3 vignettes; LISTENING in all three vignettes; EXEMPLARS in the observed interview and vignettes #2 and #3; INTUITION in the observed interview and vignettes #1 and #3; and RESOURCES in vignettes #2 and #3.

Denise rated the suicide risk of the three vignettes as follows: vignette #1: very high risk; vignette #2: pretty high risk; and vignette #3: mild to moderate risk. Denise stated she did not feel confident in her level of certainty regarding her suicide assessment ratings.

Fifth Participant—Eve

Assessment of an Actual Case. The client Eve assessed was a single Caucasian female in her early 30's with an extensive history of

polysubstance abuse and recent suicide attempt necessitating locked inpatient psychiatric treatment. The client was approaching discharge from her inpatient stay on a locked psychiatric unit and awaiting a visit from her mother who was to take her for a "therapeutic day pass." Although the client had been on the unit for an extended period, Eve had not been assigned to her prior to this time.

During the assessment session Eve sat facing the client and did not use any hospital assessment forms nor did she take any notes. She spent about 10 minutes asking the client questions about her suicide attempt. Eve's assessment was guided towards finding "ways that would help her not get to that point [suicidal] again (because there's probably still a risk)," future orientation, "how she had been doing," and "what her problems were." Eve stated, "I don't just focus on suicidality but I try and get a sense on ... every level where the person is at and that's when I feel the most comfortable. ... I will ask about that (suicidality) and I think they expect those ... questions so they're going to tell me what they think I want to hear but if I ask them about some other things, maybe they'll give me more of a genuine picture of how they're (actually) doing." Eve, also, made the assessment that the client was "quite intelligent," had "a lot of insight," and "[i]t almost seemed that it gave her a sense of relief to talk about it (suicide attempt) some more."

At the post assessment interview Eve indicated that she relied on the following strategies: (a) viewing the client holistically as an individual, (b) not focusing on suicidality rather trying to "get a sense on every level where the

person is (presently) at (biopsychosocially)," (c) hearing her story, (d) evaluating the client's future orientation, (e) the assessment of other professionals (team members) regarding the client's "readiness" for discharge, (f) assessing the client's "insightfulness," (g) directly asking about suicidality, (h) assessing the client's reported ability to "contract for safety," and (i) believing the client's statement, "I want to be alive (although she, admittedly, struggles with ongoing suicidal ideation) ... for [her] son ... and job."

Eve assessed this client to be at "low risk" for suicide. Eve felt "pretty confident" with her assessment adding, " ... [It's] not just my own assessment because I'm used to working with a team and I know what the other team people's conclusions ... about her, that she was getting ready to be discharged and was on the road to recovery." Additionally, Eve added, "My thoughts were, if everything went smoothly, she would be fine. But if something happened to her son or if she somehow got into really bad substance abuse that the risk would be higher." Of note, other than a friendly greeting, Eve was not noted to interact with the client's mother, who came to accompany the client for her pass.

Assessment of the Vignettes. Regarding the emerged categories of description in relation to the three vignettes, Eve used the majority of the categories except for reliance on SIGNIFICANT OTHERS with the exception of vignette #3, reliance on other PROFESSIONALS in vignettes #1 and #3, and INTUITION in the observed assessment of a live case and vignette #3.

Eve rated the suicide risk of the three vignettes as follows: vignette #1: high risk; vignette #2: high risk; and vignette# 3: low risk. Although Eve appeared more confident in her suicide risk assessment, she was less certain regarding the accuracy of her suicide risk assessment of vignette #3. She appeared uneasy with this vignette, indicating she had adolescents of her own.

Sixth Participant–Fran

Assessment of an Actual Case. The client Fran assessed was an 18 year old single Caucasian male who came from a residential facility for an emergency evaluation following suicidal threats and gestures; self-injurious risk taking behaviors (carving his wrist, pouring lighter fluid on himself and igniting it then quickly extinguishing the flames); punching his wrist through a wall following a “disagreement” with a residential employee for restricting a parental visit; and passive homicidal ideation toward this residential employee (“... to get back at him”). During the assessment session, Fran sat at a desk facing the client who sat to her right. Using the hospital’s psychiatric assessment form, Fran spent about 30 minutes asking questions regarding suicidal ideation, suicide attempts, psychiatric history, the client’s affect (“I felt he’s needy ... hopeless ... he felt sad ... strangeness”), family situation, his sentiments regarding his residential placement, and future plans.

Although Fran stated the “intake form” guided her assessment, she felt since the client had been in the psychiatric system for some time, he was likely

to respond according to what he felt she wanted to hear. Therefore, Fran asked questions "from different angles" to more accurately assess the client.

During the question proceeding the observed interview, Fran articulated an extensive knowledge of suicide assessment including: (a) using risk factors (e.g., age, gender), (b) observing the client's presentation (facial expression, eye contact, tone of voice), (c) evaluating the client's functioning, (d) asking about the client's sleep patterns, (e) obtaining the client's history (past attempts, family), (f) evaluating the client's future orientation, losses, and (g) asking whether the client would tell anyone if he were suicidal. Fran rated the client's suicide risk as "moderate to high" given the extent of his self-destructive behaviors and impulsivity. At the post assessment interview, Fran indicated that she relied on the following strategies: (a) directly asking the client about suicidality, (b) direct observation of the client's presentation/behaviors, (c) risk factors, (d) using the data obtained guided by the hospital's psychiatric assessment service form, and (e) mental status assessment findings (e.g., impulsivity).

Assessment of the Vignettes. Regarding the emerged categories of description in relation to the three vignettes, Fran did not articulate relying on OTHER PROFESSIONALS in the observed assessment or in any of the three vignettes; she did not rely on INTUITION in any of the three vignettes; she did not demonstrate reliance on RESOURCES or LISTENING in vignettes #2 and #3. Additionally, she did not rely on SIGNIFICANT OTHERS in the observed assessment and vignette #2. However, Fran demonstrated reliance on RISK

FACTORS, ASSOCIATED STATES, and PLAN/FEASIBILITY throughout the observed assessment and all three vignettes.

Fran rated the suicide risk of the vignettes as follows: vignette #1: high risk; vignette #2: high; and vignette #3: moderate. Unlike Beth, Fran was most adamant about hospitalizing the adolescent in vignette #3.

Summary

In summary, participants used a number of similar and different strategies with variability in their approaches to suicide assessment. However, it is essential to mention that assessment is a complex process. Furthermore, given the complexities of suicide assessment, it is understandable that accurate, precise assessment remains challenging and often problematic. Undoubtedly, the nurse participants in this study were overall knowledgeable and skillful in performing this tremendously complex role. In any event, given risk under uncertainty, nurses need to be conservative in their suicide assessments to prevent lethal outcomes.

Participants' Assessment in Relation to Practice Guidelines

(Research Question #3)

For research question #3 (i.e., How do the strategies of suicide assessment used by the psychiatric-mental health nurses compare with current practice guidelines on suicide assessment?), the participants' strategies of suicide assessment were compared to "The Harvard University

Suicide Assessment Protocol Guidelines.” This protocol provides a current and credible set of practice guidelines.

The Harvard University Suicide Assessment Protocol Guidelines (Guidelines) were developed in 1999 and consists of five categories developed to provide suicide assessment practice guidelines for clinicians (Jacobs, Brewer, Klein-Benheim, 1999) (Appendix B). A comparison of the suicide assessment strategies used by the nurse participants in this study and these five categories is presented in this section. Of note, none of the participants responded affirmatively when asked if they used practice guidelines in their suicide risk assessments.

I. Consider Predisposing Factors: Axis I Diagnosis

The following five areas are specified in the Guidelines for suicide assessment for the dimension of “Consider Predisposing Factors”:

- a. Affective illness: 15 percent lifetime risk of suicide, 60 percent of suicides
- b. Schizophrenia: 10 percent life risk of suicide, 10 percent of suicides
- c. Alcohol and other substance abuse: 3-5 percent lifetime risk of suicide, 25 percent of suicides
- d. Evaluation of category of disorder, time course of illness, clinical features
- e. Comorbidity

The nurse participants articulated some knowledge of risk factors as the key areas to consider in assessing for suicidality. However, the results of this

study illustrate inconsistencies and variability in the assessment strategies used by the participants. None of the participants enumerated all of five areas noted in the Guidelines above. Some participants were more comprehensive in their conceptualizations of the numerous risk factors, whereas others were less inclusive. For example, all participants assessed for depression and substance abuse yet only one participant assessed for bipolar illness. Furthermore, one participant did not assess the adolescent (a particularly high suicide risk group) who had recently attempted suicide (Vignette #3), as being suicidal enough to require inpatient hospitalization.

All nurse participants demonstrated their understanding and application of comprehensively assessing particular at risk populations (e.g., depressed and substance abusing clients). However, consideration of other specific disorders such as schizophrenia was not articulated. Furthermore, *modifiable* risk factors, such as panic, or anxiety, were not specifically identified by the majority of participants. Rather, specific symptoms and clinical features such as hallucinations, paranoia, and impulsivity were areas of focus skillfully assessed.

As a predisposing factor, interpersonal loss, an important precipitant to suicide, was identified by all participants and strategies were used to assess the impact of loss on the individual and relationship to suicide risk (e.g., vignette #2 in which the woman lost her children in a motor vehicle accident and, also, lost her previous functional capacity).

The nurses seemed to consider the meaning and weight of specific risk factors that were evident in the clients identified from their knowledge of the clients' backgrounds, rather than having a specific list of risk factors to be checked in assessment.

II. Detect Potentiating Factors

The Guidelines identify the following seven areas within the "Detect Potentiating Factors":

- a. Family and social milieu
- b. Personality disorders and traits
- c. Antisocial personality disorder (males)
- d. Narcissistic personality disorder
- e. Physical illness
- f. Life stress or crisis
- g. Firearms and other available methods

All participants used strategies for suicide assessment focusing on biological vulnerability, life stress, crisis, and availability of methods for suicide. All participants considered suicide risk in relation to family and social supports, however, assessment of specific family dynamics and social milieu was the focus of only one participant. All participants specifically inquired about interpersonal dynamics yet personality disorders and/or traits were not a focus of assessment. However, their attention to personality disorders as potentiating factors was neither systematic nor comprehensive. Participants consistently were engaged in assessing and managing general medically

related issues, a vital prerequisite skill in suicide risk assessment and a general strength in contemporary nursing practice. Although all participants seemed to be alert to the availability of methods for suicide in their clients, no participant specifically inquired about firearm availability. Additionally, none of the participants identified panic anxiety as an important *modifiable* risk factor.

III. Conduct a Specific Suicide Inquiry

Two areas are included in "Conduct a Specific Suicide Inquiry" in the Guidelines: (a) determination made of suicidal ideation and intent and (b) assessment of suicide plans and attempts. All participants used specific strategies to assess suicidal ideation, plans, and attempts. They were all knowledgeable and skilled in conducting a suicide inquiry. All participants asked clients directly about their past and current ideation, plans, and attempts. However, there was considerable variability between the nurses regarding the depth, breadth, and clarity of inquiry. For example, one participant relied on prior assessments made by other team members (i.e., other team member's prior assessment and communication that the client was no longer suicidal despite the recent suicide attempt by the client and capable of a "therapeutic day pass" out of the hospital); another participant specifically asked the client if she would be able to approach the staff, using the psychiatric term, "contracting for safety." Many clients are confused by this term or may not be able to, understandably, assess their own level of safety. Therefore, this strategy to assessment may be unreliable.

IV. Determine the Level of Intervention

This category is identified with five specific areas of focus:

- a. More control taken by clinician when patient has disorder-based suicidality
- b. More control given to patient who has personality-based suicidality
- c. Assessment made of patient's compliance (judgment, level of compliance, ability to understand treatment)
- d. Assessment made of therapeutic alliance
- e. Reassessment of suicidality scheduled

The participants working in psychiatric assessment service (where rapid data collection even amidst crisis, time, and other constraints is essential) spent more time with clients compared with participants practicing on the inpatient unit. In this setting nurses perform "brief check-ins" which is often routine practice in settings where staff are familiar with the client's history (e.g., time limited, symptom focused assessment periodically done throughout a client's inpatient treatment and when a client is scheduled for a "therapeutic pass" off the unit to assess the client's ability to adhere to the purpose of the "pass" and accompanying viable expectations).

All participants working in the psychiatric assessment service used strategies to assess the "level of care" needed by the patients and focused on the nature of disposition. Specific areas of assessment included client's judgment, insight, level of compliance, and ability to participate in treatment.

The participants working in the locked psychiatric units demonstrated using strategies also focusing on patient's judgment, insight, and compliance.

The participants did not use different assessment strategies regarding their approach to intervention according to specific causal frames of suicide in the clients. That is, the participants did not differentiate their assessment strategies in relation to whether the client's suicidality was disorder-based or personality-based. In addition, the participants did not articulate seeking out information from their clients regarding the clients' alliances with psychiatric professionals for therapy in their past or the present therapeutic alliance.

V. Documentation

This category refers to the documentation of assessments as a requirement for assuring communication. Due to confidentiality, the researcher did not examine documentations completed by the participants in the client records. However, it was observed that extensive documentation via the psychiatric assessment service intake form was performed by every participant.

Summary

In summary, although none of the participants used suicide assessment clinical guidelines, all participants incorporated various suicide assessment strategies from the literature. However, without the use of structured practice guidelines, the participants did not perform a comprehensive suicide assessment as defined by the Guidelines. Additionally, none of the participants utilized any well established suicide assessment instruments.

Four of the participants expressed that quantitatively oriented instruments would be useful, while one felt it would detract from the nurse-client relationship.

Participants' Assessment in Relation to Education and Experience

(Research Question #4)

For research question #4 (i.e., "How do nurses perceive education and/or experience influencing their suicide assessments?"), the following summarizes the nurse participants' perceptions regarding how their education and/or experience influenced their suicide assessment.

First Participant–Amy

At the completion of earning her baccalaureate education, Amy did not feel adequately prepared to perform suicide assessments. Amy reported her clinical practice as a psychiatric-mental health nurse combined with education at the master's level (MSN) and in-service education provided her with the knowledge and skills necessary to adequately prepare her to perform this type of assessment. Despite her educational and clinical preparation, Amy stated, "not a day goes by that I don't wonder if I made the correct assessment." Amy attributed this to the complexities of suicide assessment.

Second Participant–Beth

Upon completion of earning her baccalaureate degree in nursing, Beth did not feel adequately prepared to perform suicide assessments. Beth

reportedly developed this knowledge and skill through her clinical psychiatric experience and in-service education.

Third Participant–Carol

Carol stated that her basic nursing education did not adequately prepare her to perform suicide assessments. Carol reportedly developed this knowledge and skill through her clinical experience and general continuing education (not necessarily specific to suicide assessment [e.g., thanatology]). Of note, Carol was the only participant that alluded to the importance of assessing religious affiliation. She, also, spoke of her own past “history” and “therapeutic use of self” impacting her nursing practice.

Fourth Participant–Denise

Denise stated her basic nursing education did not adequately prepare her for suicide assessment. As with the previous participants, Beth reported her clinical experience in psychiatric-mental health as the source for her preparation in assessing clients for suicide. The foundation of her knowledge and skill in suicide assessment was from her role as a mental health worker, which involved direct client care. Although Denise only has an associate’s degree in nursing and minimal experience as a psychiatric-mental health nurse (nine months), she was strikingly knowledgeable about suicide assessment. However, she did express the greatest uncertainty about the accuracy of her findings.

Fifth Participant—Eve

Although Eve felt her basic nursing education provided her with a “holistic” view of clients, she did not feel it adequately prepared her for suicide assessment. Reportedly, her clinical experience in psychiatric-mental health has prepared her in suicide assessment. In fact, Eve jokingly emphasized that she is a graduate of “The X Hospital School of Psychiatric Nursing” in which she attributes the experience and learning attained in this psychiatric teaching hospital (which she is not currently employed) as preparing her for suicide assessment. Eve, as did Amy, acknowledged the complexity of suicide assessment and repeatedly stated, “If I’m going to make a mistake, I’m going to make it on the side of safety.”

Sixth Participant—Fran

Fran stated that she was not adequately prepared to perform suicide assessments in her associate degree program and as with the other five participants, Fran states that her clinical experience and/or in-service education were the sources of this preparation.

Summary

All participants were asked how they perceived their education influencing their suicide assessments. They all responded that they did not believe their basic nursing education adequately prepared them for suicide assessment. Rather, their experience, on-the-job training, in-service education, and/or continuing education best prepared them for this challenging role and responsibility. Four participants attended in-service education in

suicide assessment. However, one participant admittedly stated it would be impossible to recall everything given the plethora of content covered.

A note regarding on-the-job training is in order. Peplau (1952), a nurse theorist, developed the anxiety continuum, in part, highlighting the impact of various levels of anxiety on learning. Thus, a nurse who may be experiencing higher levels of on-the-job anxiety in an already anxiety producing environment, may be incapable of adequately learning or incorporating critical suicide assessment via on the job preparation. Additionally, the quality of on-the-job training depends on adequate and available opportunities to assess diverse clients as well as the competency of those providing the experiential "learning" opportunities. Similarly, in-service and continuing educational programs vary in efficacy contingent on the content and context of presentation (e.g., exclusively didactic or role playing/modeling) and the style of participant learning.

Comparison of the Findings Across Participants

The details of the number of the various categories that emerged in this study used by different participants are given in Table 1.

Table 1. Number of Participants Using Categories

Category	Code	Actual Case	Vignette 1	Vignette 2	Vignette 3
Risk Factors	C01	6	6	6	6
Associated States	C02	6	6	6	6
Resources	C03	6	6	3	3
Listen	C04	6	3	0	3
Plan/Feasibility	C05	6	6	6	5
Exemplars	C06	2	3	2	2
Intuition	C07	2	1	3	1
Significant Others	C08	2	3	0	5
Other Professionals	C09	4	2	2	0
Related Stories	C10	5	4	4	5

Overall, all participants demonstrated knowledge of some RISK FACTORS in their suicide assessments. However, the major risk factor identified consistently across the participants was depression. Other risk factors were not systematically identified by the participants. The participants did not use tools such as the SADPERSONS scale in order to assess risk factors. All participants demonstrated knowledge of psychological states commonly associated with suicidality yet not all participants acknowledged some commonly known ASSOCIATED STATES (e.g., agitation followed by calmness in the case of vignette #2).

Throughout the assessments of the observed cases and the vignettes, Amy did not rely on EXEMPLARS, Carol did not rely on INTUITION, Denise did not rely on the SIGNIFICANT OTHERS or RELATED STORIES, and both Beth and Fran did not rely on OTHER PROFESSIONALS. Similarly, Amy and Denise (with the exception of the assessments of the observed cases) did not

rely on OTHER PROFESSIONALS. It may suggest, in part, that these nurses (Amy, Beth, and Denise) function rather independently in their autonomous roles and because of their clinical experiences spanning decades. All participants, with the exception of Denise, felt their general understanding (conceptualization) of suicide influenced their practice in suicide assessment. The suicide assessments by all participants were notably more extensive for the observed cases compared to the vignettes (in which many felt the vignettes provided "scanty" data). None of the participants used an established suicide assessment instrument. All participants demonstrated and/or articulated their holistic nursing practice approach and the development of therapeutic nurse-client relationships and "therapeutic use of self." All participants either directly asked their clients if they were suicidal and/or used individualized strategies (e.g., future orientation, insight, judgment, impulsivity) in their suicide assessments.

Analysis of the ratings of the three vignettes by each of the nurse participants, although evidencing variability, did not show any discernable differences in relation to academic or experiential preparation. Table 2 shows the variations in the ratings of the vignettes by the nurse participants, indicating that the variation is most evident in the case of Andrew (Vignette #1) ranging from moderate to very high. Similarly, variation in rating the adolescent in vignette #3 ranged from low to high. It is noteworthy that four participants rated the adolescent's suicide risk as low when suicide rates for adolescents have increased threefold since 1955 and suicide is the third

leading cause of death (National Center for Health Statistics, 1992) for this vulnerable population.

Table 2. Participant Ratings of Suicide Risk of Vignettes

Participant	Degree*	Experience**	Vignette 1	Vignette 2	Vignette 3
Amy	MSN	25 years	moderate	high	low
Beth	BSN	26 years	high	moderate	low
Carol	BSN	15 years	med.-high	high	high
Denise	ADN	9 months	very high risk	pretty high risk	mild to moderate
Eve	BSN	19 years	high enough	high	low
Fran	ADN	23 years	moderate	high	low

* highest nursing degree earned

** psychiatric-mental health nursing experience

CHAPTER V

CONCLUSIONS AND IMPLICATIONS

Main Findings

This study explored suicide assessment by psychiatric-mental health nurses. The aim of the study was to develop phenomenographic categories of description of suicide assessment, through observations and in-depth interviews. The findings that emerged have implications for contributing to nursing knowledge development, practice, education, administration, and research.

The participants in the study, in performing suicide assessments, relied on several different strategies among the common 10 categories that emerged as the core set of strategies. In most cases the nurses used between four and six different strategies in combination rather than relying solely on one specific strategy. This may be due to the complex nature of suicide as a phenomenon and the nurses tendency to be conservative in regard to this diagnostic responsibility as misdiagnosing has a "serious" consequence. In addition, the nurses were neither comprehensive nor systematic in seeking information from clients regarding risk factors and potentiating factors for suicide risk. This may be due to gaps in knowledge regarding suicidality or the tendency to focus more on common risk factors rather than using a comprehensive list of possible ones. This may be due to the processing of information adopting cognitive short-cuts such as cognitive heuristics of representativeness, availability, and anchoring (Kahneman & Tversky, 1973).

The assessments of three vignettes by the nurses tended to be less elaborate and more conservative in their ratings of suicidal risk. That is, in general the nurses used fewer strategies in assessing these cases compared to the assessments of observed cases. This may be due to the inability to seek additional information besides that present in the vignettes.

The characteristics of 10 categories of description regarding suicide assessment can be classified into three different dimensions: (a) those seeking to assess the presence or absence of conditions, states, or experiences that are frequently prevalent in suicidal clients, (b) those related to the methods of assessing, that is, ways of obtaining information, and (c) those related to the processes of formulating ideas regarding clients' situations especially in relation to suicidal risk. The first dimension includes the categories of RISK FACTORS, ASSOCIATED STATES, RESOURCES, PLAN/FEASIBILITY, AND RELATED STORIES which are oriented to seeking evidence that are usually present in clients with suicidality and is related to the nurses' knowledge and conceptions of suicide. Hence, this dimension may be termed *the Knowledge Dimension*, as what specific aspects or conditions are considered important in using these categories seem to depend on the extensiveness and comprehensiveness of the nurses' knowledge regarding factors that contribute to suicide risk and suicide.

The second dimension refers to those strategies of assessment used as ways of getting additional information, and includes LISTENING and SIGNIFICANT OTHERS' PERCEPTIONS. The nurses are using these

strategies in order to gain information and perceptions directly from clients and their significant others. These are critical strategies when inner-most thoughts and feelings are at the core of clients' problems (e.g., suicide). Paying attention to what is said, how it is said, nonverbal behavior, information revealed by clients, and the perceptions of significant others who have had prolonged contacts with clients are important ways of gaining insights into clients' past history and current psychological status. This dimension may be termed *the Method Dimension* as its characteristic is in ways of gaining information.

The third dimension includes the categories of EXEMPLARS, INTUITION, and OTHER PROFESSIONALS. The focus of this dimension is on how the nurses come to formulate ideas about clients' situations. They rely on comparing a current client situation vis-à-vis exemplar cases, relying on their gut feelings and intuitions as to what the client's situation means, or resorting to and relying on decisions and diagnoses made by other professionals. These are strategies used to come to form ideas about the meanings of client situations, and may be termed *the Reference Dimension*. The "*Reference Dimension*" is oriented to strategies related to how one forms an idea – the process, in the sense of "I refer to my intuition" or "I refer to what the doctor said" or "I refer to what a typical case is like."

This structure of 10 categories of descriptions shown in Figure 2 indicates that suicide assessment involves a multidimensional process within which variations among the nurse participants were found. This insight into

the structure of assessment has theoretical implications regarding our understanding of suicide assessment and nursing assessment in general. This may mean that nurses are engaged in assessment of clients guided not only by their knowledge and conceptualizations of phenomena of interest but also by various methods of obtaining information and reliance on different sorts of referential bases for decision making. This is in line with Sjöström's findings (1998) regarding pain assessment in that in his study nurses were found to rely on the way patients looks and what they say (the knowledge dimension), the ways of talking (the method dimension), and what it usually means (the reference dimension). Theoretically this leads to further questions regarding the frames of significance nurses must address in assessing clients, especially when their focus is on specific problems such as suicidal risk, pain, fatigue, confusion, or knowledge deficit rather than when they are involved in general assessment of clients. General assessment of clients often occurring on admission may be characteristically quite different from the more pointed assessment regarding specific problems. This descriptive work is an important beginning for the development of a theory of nursing assessment.

Figure 2. Structure of suicide assessment

Future Direction for Nursing Knowledge Development

Improved understanding of how nurses conceptualize and assess suicidality has critical significance in suicide prevention and intervention. The findings of this study could contribute to Kim's (1983, 1987, 2000) extensive work in knowledge development regarding nursing practice and add to theory development regarding nursing assessment as one of the critical phenomena in the practice domain.

This study has led to the identification of other potential areas in need of knowledge development and inquiry. For example, this study did not investigate the quality of suicide assessment or the outcomes of specific

suicide assessments on nursing actions (enactment). There is a need to develop theoretical understanding about the relationships between the specific strategies used by nurses and outcomes of the patterns of use both on nursing actions and clients. Furthermore, the theoretical structure that emerged from this investigation leads to questions such as how the bases for *the Knowledge Dimension* become established in nurses, and why certain nurses are more likely to rely on the strategies in *the Method Dimension* or *the Reference Dimension* than on those within *the Knowledge Dimension* while others tend to rely heavily on the strategies of *the Knowledge Dimension*. In addition, it is critical to discover whether or not this structure applies to various other types of nursing assessment. This can lead to a middle-range theory of nursing assessment.

Furthermore, the findings that the nurses rarely use any of the standard, pre-established guidelines in suicide assessment, suggest a need for further investigations on the reasons and consequences of this practice.

Methodological Implications

Phenomenography, the methodologic approach of this study provided a meaningful way to systematically study participants' conceptualizations of suicide and strategies used for suicide assessment. The methodological rigor and the richness of the data collected through the use of observations and semi-structured interviews validated the utility of utilizing this method in the development of nursing knowledge. The process of data analysis, as applied in this investigation, had been specified in detail by the proponents of

phenomenography and provided a framework for analytical rigor. One of the major requisites in data analysis is involving other researchers who are familiar with phenomenography in various phases of data analysis. It is critical to receive feedback and validation from credible researchers regarding emerging categories and condensations.

Vignettes were used in addition to actual cases for suicide assessment because of an anticipated difficulty in obtaining clients in suicide-prone states. Although the use of vignettes was satisfactory in confirming various strategies of assessment used by the nurses, there were a few problems in its use. First, the nurses in general felt that the information provided in the vignettes was neither detailed nor comprehensive enough for the purposes of assessment. Secondly, the inability of nurses to obtain data from clients in a progressive, on-going manner through dialogue and observation seems to have limited their processing of information. This, too, speaks to the need to study the effectiveness of the use of simulated case studies as a teaching method. Methodologically, if vignettes are to be used in this type of research, it may be better to use interactively based vignettes (using computers) whereby participants could obtain additional data on request.

As a developing and pragmatic method, the use of phenomenography presented unique challenges. For example, since the members of the Institutional Review Boards (IRB's) were not familiar with this method, education of the members of the IRB's was necessary (Appendix M). As a result, beginning this study was significantly delayed.

Accessing informed consent from the patients being assessed by the nurses was often difficult. Flexibility, time, and patience were key to achieving the goals of the study. Repeated visits were required to obtain sufficient data, accommodate the nurses' schedules, and be sensitive to the needs of the system. At times the nurses were too busy to participate due to the high number of patients that needed assessments.

Implications for Nursing Practice

As a practice profession, it is essential that nurses build upon their knowledge of suicide assessment in order to further develop more effective client-focused deliberative and enactment interventions, thus, improving the quality and outcome of nursing care.

The findings of this study have led to the following implications for nursing practice. Given that all participants identified their clinical experience (practice) as the primary mechanism for developing suicide assessment skills, there is a crucial need for increased clinical experience, role modeling, mentoring, in-service, and adequate continuing education. Similarly, given the great variability in performing a suicide assessment for the adolescent in vignette #3, particular attention to the various clinical presentations and required nursing strategies in assessing diverse clientele throughout the life span is warranted.

In addition, since some nurses relied on other nurses' or professionals' assessments as the bases for coming to assessment decisions, it is critical to assure the overall quality of assessment in practice situations. It may be

necessary to develop organizational programs in which professionals involved in assessments dialogue about the strategies and processes of assessment specifically focusing on the quality of outcomes. If the tendency to rely on others continues, then the best way to assure assessments of a high quality is through creating a culture of excellence in the clinical practice arena.

Implications for Nursing Education

This study points to the necessity for educating nursing students in suicide assessment. It is recommended that nurse educators re-evaluate their course content and practicum experiences, placing greater emphasis on providing students with the opportunity to perform suicide assessments.

Continuing education programs for practicing psychiatric-mental health nurses need to focus on helping practitioners gain insights into their own practice in order to understand the strategies that are used by them and what potential consequences are in using them. It would be beneficial to educate psychiatric-mental health nurses on the method of Critical Reflective Inquiry suggested by Kim (2000) in order to have the nurses examine their own assessment practices thereby gaining self-understanding about the strategies used.

Nurse educators should also include more theoretically-based suicide assessment content and incorporate the work of nurse theorists as a theoretical foundation. Furthermore, given the nursing shortage and an increase in the appeal of non-traditional accelerated nursing degree programs (e.g., second degree, "fast track," "online," and BSN-PhD), it is critical that

nurse educators include in courses dealing with suicide assessment normative theories, related skills of assessment, and the descriptive theories and findings about the nature of actual practice in order to show that disparities in practice exists.

Implications for Nursing Research

As a result of this study, it is recommended that additional research be conducted to investigate similarities and differences in the conceptualizations of suicide and strategies for suicide assessment by novice versus expert nurses and heterogeneity. Furthermore, research investigating diagnostic reasoning; intuition and transference in suicide assessment; and/or errors in clinical decision making is sorely needed.

Additionally, it is recommended research be conducted to investigate the actual versus perceived needs by some nurses to incorporate quantitative suicide assessment instruments into routine practice and whether such quantitative instruments serve utility or detract from the nurse-client relationship. Research examining the use of standardized suicide protocols and/or suicide assessment instruments is critical. However, as the first step, there is a need to develop theoretically grounded, valid, and reliable instruments that can be incorporated into quantitative measurement protocols.

As suggested earlier, it is important to investigate further how extensive the strategies, discovered in this study, are used by psychiatric-mental health nurses in assessing clients for suicidality. Through various validation studies,

it would be possible to develop a more insightful descriptive theory of suicide assessment.

Implications for Nursing Administration

Nurse administrators play a critical role in examining current standards of nursing practice in suicide assessment and determining the educational needs of nursing staff specific to suicide assessment. It is recommended that nursing administration allocate the necessary resources to provide in-service education, preceptorships, and/or mentoring of nursing staff. Additionally in view of "cut-backs" in the health care delivery system, the valuable contributions by psychiatric-mental health clinical nurse specialists requires reconsideration of the allocation of resources.

Concluding Remarks

The findings of this investigation are descriptive and were discovered in the nurses' practice. The emphasis one must make in such a study is that the results do not address what are correct or incorrect ways of practicing. However, the insights regarding what actually occurs in practice provide an important starting point for developing knowledge about nursing practice. Nursing assessment as one of the most important nursing responsibilities requires not only an in-depth understanding but also a normative theory. This study is the first step toward such a goal.

APPENDICES

Appendix A: SADPERSONS Scale

Sex	Males suicide 3 times more than females Females attempt suicide 3 times more than males.
Age	High-risk groups: 19 years or younger; 45 years or older (especially over 65 years).
Depression	Research reports 35-79% of those who attempt suicide exhibit a depressive syndrome.
Previous attempts	65-70% who commit suicide have made previous attempt.
ETOH (alcohol)	Alcohol is associated with 65% of completed suicides. Estimates are that 15% of alcoholics complete suicide. Heavy drug use is given the same weighing as alcohol.
Rational thinking loss	Individuals with organic or functional psychoses are more likely to suicide than the general population.
Social support lacking	A suicidal individual often lacks significant others, meaningful employment, and spiritual support.
Organized plan	A specific suicide plan (date, location, means) signifies high risk.
No spouse	Repeated research demonstrate individuals who are single, separated, widowed, or divorced are at higher risk than those who are married.
Sickness	Chronic, debilitating, and severe illness are high risk factors. Suicide risk is 2 times greater among individuals with cancer and high among AIDS clients. Clients with delirious tremors, on hemodialysis and suffering from respiratory diseases are all at high risk.
	<u>Rating:</u> A positive factor counts one point.
	<u>Scoring:</u>
	0-2 = Little risk
	3-4 = Follow closely
	5-6 = Strongly, consider psychiatric hospitalization
	7-10 = very high risk, hospitalize or commit

Source: Patterson, Dohn, Bird, & Patterson, 1983

Appendix B: The Harvard University Suicide Assessment Protocol Guidelines

Consider Predisposing Factors: Axis I Diagnosis

Affective illness: 15 percent lifetime risk of suicide, 60 percent of suicides

- Risk related to severity

- Risk highest in depressive states

- Anxiety or panic as modifiable risk factor

Schizophrenia: 10 percent life risk of suicide, 10 percent of suicides

- Higher risk for paranoid type

- Risk usually higher after recover from psychotic phase

- High correlation between depression or depressive symptoms and suicide

Alcohol and other substance abuse: 3-5 percent lifetime risk of suicide,

25 percent of suicides

- Alcohol use very prevalent in suicides

- Interpersonal loss important as precipitant

- Mechanism unclear (increased impulsivity?)

Evaluation of category of disorder, time course of illness, clinical features; and

Comorbidity

Detect Potentiating Factors

Family and social milieu

- Biological vulnerability

- Interpersonal dynamics and family construct

Personality disorders and traits

- Borderline personality disorder

- Clinician differentiates between self-mutilation and suicide attempts

- Clinician inquires into intent

Antisocial personality disorder (males)

Narcissistic personality disorder

- Extreme narcissistic injury as stimulus

- Correlation with attachment syndrome in murder-suicide

Physical illness

Life stress or crisis

Firearms and other available methods

Conduct a Specific Suicide Inquiry

Determination made of suicidal ideation and intent

Assessment of suicide plans and attempts

Determine the Level of Intervention

More control taken by clinician when patient has disorder-based suicidality

More control given to patient who has personality-based suicidality

Assessment made of patient's compliance (judgment, level of compliance, ability to understand treatment)

Assessment made of therapeutic alliance
Reassessment of suicidality scheduled

Document the Assessments

Source:

Jacobs, D. G., Brewer, M., & Klein-Benheim. (1999). Suicide assessment: An overview and recommended protocol. p. 39. In D. G. Jacobs (Ed.). The Harvard Medical School guide to suicide assessment and intervention. San Francisco, CA: Jossey-Bass Inc.

Appendix C: Schematic Representation of Research Design

Appendix D: Clinical Vignettes

Clinical Vignettes*

Instructions:

Please read the following 3 clinical vignettes and rate them according to your assessment of the lowest, moderate, and highest suicidal risk. Once you have read the scenarios, the nurse researcher will ask you questions about them. Keep in mind there are no true correct or incorrect responses.

1. Betsy is a seventeen-year old high school student who is angry at her parents for not letting her go on a weekend trip with friends. To make them regret restricting her, she took ten of her mother's Valium® leaving a suicidal note, but was found immediately. She was brought in to an ER, and was treated and is recovering. You are to assess this patient now.
2. Andrew has been working at the same mill for the last thirty years. This week his company announced that it will close the mill and permanently lay off all of the personnel. He is pessimistic about finding a new job because of the large number of people in the area who are looking for work. Due to a chronic illness, his wife requires constant medical attention; by losing both his salary and his health insurance coverage, Andrew sees no way to provide her with the care she needs—except by killing himself so that she can collect his life insurance. One of his close friends has been quite concerned about his emotional state, and has brought him to a mental health clinic. You are to assess this patient.
3. While driving in an intoxicated state, Martha lost control of her car and ran into a tree. Her two children died in the accident and she was paralyzed from the waist down. During her hospitalization she tried to kill herself by cutting her neck with a piece of broken glass. Now that she is home, she continues to feel guilty over the deaths of her children and hopeless about her future life in a wheelchair. But the agitation and distress of recent weeks have been replaced by an air of calmness. She has saved her prescription pain medication and she now has a large enough dose to kill herself. She has been seen by a psychiatric clinician on a continuing basis since her accident. Now, you are to assess her status.

*Adapted from: France, K. (1989). *Crisis intervention: A handbook of immediate person-to-person help* (2nd. Ed.). Springfield, IL: Charles C. Thomas Publisher, p. 100

Appendix E: Consent Forms For Research

The University of Rhode Island
College of Nursing
Kingston, RI 02881

Suicide Assessment

CONSENT FORM FOR RESEARCH

You have been asked to take part in a research project described below. The researcher, John M. Aflague, Ph.D.(c), M.S., RN, CS, will explain the project to you in detail. You should feel free to ask questions. If you have more questions later, John M. Aflague, the person mainly responsible for this study -----, will discuss them with you.

Description of the Project

You have been asked to take part in a study which will explore the ways nurses perform suicide assessment.

What will be done

If you decide to take part in this study here is what will happen. Once your questions have been satisfactorily and fully answered, this researcher will obtain your signed and dated informed consent. A copy of the consent will be promptly given to you. Your confidentiality is guaranteed. You will complete and return a brief demographic data sheet.

You will ask potential adult patients' permission for this researcher to observe you interview them. Inclusion criteria for consenting adult patients will be that they are 18 years of age or older, can speak English, and are competent to provide informed consent for observations (i.e., individuals with guardians or who are court mandated will be excluded). Each eligible patient will be informed that I am a nurse studying nurses in practice by observing them interview patients. Patients will be informed that their decision (to participate or not) will not effect their care. You will also obtain signed and dated consent from the patient. This consent will also be signed and dated by you and this researcher. Once patient consent is obtained, this researcher will observe you perform a suicide assessment on one appropriate consenting adult patient. If a patient does not formally consent or there is a disruption in agency routine (at any time), this researcher will remove himself.

During the observational period, this researcher will be located on the periphery observing you interview the patient. As soon as possible following the observation session, this researcher will arrange a conversational interview with you. The conversational interview will be conducted in a private

area in the clinical setting or mutually negotiated place away from others to maintain confidentiality, freedom of speech, and provide a conducive environment. During this time, this nurse researcher will ask you to share how you go about performing suicide assessment of patients. The interviews will take place "off duty." This interview (~1 hour) will be audio taped.

At a convenient time (which could occur on the same day of the patient observation and conversational interview as outlined above and as follows:), you will also be asked to read 3 brief vignettes. Next (at a convenient time, ideally as soon as possible after reading the 3 vignettes), you will be asked to verbally respond to the 3 vignettes in a conversational interview with the researcher by providing your assessment of the factitious scenarios and answering questions related to the 3 vignettes in a conversational interview with this nurse researcher. This interview (~1 hour) will also be audio taped. The researcher may ask to call you for further questions and clarification. You may decline to answer any question or questions.

Risks or discomfort

In the process of the interview you may experience some distress in discussing suicide assessment or feel uncomfortable being observed by a nonjudgmental nurse researcher, otherwise, there are no other risks or discomforts known.

Benefits of this study

Although the results of this study may not be of direct or immediate benefit to you, the information obtained from the study has potential important implications for nursing practice and education. If nurses can better understand the process(es) by which nurses assess patients,' educational opportunities can be designed to enhance this role. The results can improve care and patient outcomes.

Confidentiality

The information that you provide will be used for research purposes only, including teaching and publication. Your participation in this study is confidential.

Due to the sensitive nature of the study, consent forms and identifying face sheets will be kept separate from the rest of the study and secured in locked boxes at the researcher's office as outlined. The listing of your name and assigned code number will be recorded on a separate sheet filed in a locked drawer to whom only the investigator has access. All records, including notes and transcribed interviews, will not identify you by name and will be kept locked in a file cabinet. A code number will identify the interview. Audiotapes will be kept in a separate locked file cabinet. Your name will not appear on the audiotape label. A number, assigned by this researcher, will appear on the

audiotape label. Because the audiotapes have intrinsic value for future research, they will be kept in a locked cabinet for at least three years. Patient consent forms will not identify the patient as seeking psychiatric services. These forms will be kept locked in a separate locked file cabinet in another location for at least three years.

Decision to quit at any time

The decision to take part in this study is up to you. You do not have to participate. If you decide to take part in the study, you may quit at any time. Whatever you decide will in no way affect your job, status in nursing services or job evaluation. If you wish to quit, you simply inform John M. Aflague at ----- of your decision.

Rights and Complaints

If you are not satisfied with the way this study is performed, you may discuss your complaints with John M. Aflague or with his major professor, Dr. Hesook Suzie Kim, Ph.D., R.N., College of Nursing, University of Rhode Island at (401) 874-5329, anonymously, if you choose. In addition, you may contact the office of the Vice Provost for Graduate Studies, Research and Outreach, 70 Lower College Road, Suite 2, University of Rhode Island, Kingston, Rhode Island, telephone: (401) 874-4328.

You have read the Consent Form. Your questions have been satisfactorily and fully answered. Your signature on this form means that you understand the information and you agree to participate in this study. Your signature also indicates that you have received a copy of this consent form.

Signature of Participant:

Signature of Researcher:

Typed/Printed Name:

Typed/Printed Name:

John M. Aflague, Ph.D.(c), M.S., R.N., C.S.

Date:

Date:

CONSENT FOR PARTICIPATION IN A RESEARCH PROJECT

(University Affiliated Acute Urban Psychiatric Hospital)

*Suicide Assessment by Psychiatric-Mental Health Nurses:
 A Phenomenographic Study*

R.N. PARTICIPANT INFORMED CONSENT

Invitation to Participate and Description of Project

You are invited to participate in a study designed to investigate suicide assessment by psychiatric-mental health nurses. You have been invited to participate because you are a registered psychiatric-mental health nurse and have been identified by a colleague as being potentially interested in participation. Your participation in the study would last *approximately one day to four weeks*. It will require approximately two to four hours.

In order to decide whether or not you wish to be a part of this research study, you should know enough about its risks and benefits to make an informed judgment. This consent form gives you detailed information about the research study which a member of the research team will discuss with you. This discussion should go over all aspects of this research: its purpose, the procedures that will be performed, any risks of the procedures, possible benefits and possible alternative treatments. Once you understand the study, you will be asked if you wish to participate; if so, you will be asked to sign this form.

Description of Procedures

If you decide to participate in this study here is what will happen. Once your questions have been satisfactorily and fully answered, this researcher will obtain your signed and dated informed consent. A copy of the consent will be promptly given to you. You will complete and return a brief demographic data sheet.

You will ask potential adult patients' permission for this researcher to observe you interview them. Inclusion criteria for consenting adult patients will be that they are 18 years of age or older, can speak English, and are competent to provide informed consent for observations (i.e., individuals with guardians or who are court mandated will be excluded). Each eligible patient will be informed that the researcher is a nurse studying nurses in practice by observing them for periods of time. Patients will be informed that their decision (to participate or not) will not effect their care. You will also obtain signed and dated consent from the patient. This consent will also be signed and dated by you and this researcher. Once patient consent is obtained, this researcher will observe you perform a suicide assessment on one appropriate

consenting adult patient. If a patient does not formally consent or there is a disruption in agency routine (at any time), this researcher will remove himself.

During the observational period, this researcher will be located on the periphery observing you interview the patient. As soon as possible following the observation session, this researcher will arrange a conversational interview with you. The conversational interview will be conducted in a private area in the clinical setting or mutually negotiated place away from others to maintain confidentiality, freedom of speech, and provide a conducive environment. During this time, this nurse researcher will ask you to share how you go about performing suicide assessment of patients. The interviews will take place "off duty." This interview (~1 hour) will be audio taped. You understand that every effort will be made to not identify me on the recording(s).

At a convenient time (which could occur on the same day of the patient observation and conversational interview as outlined above and as follows:), you will also be asked to read 3 brief vignettes. Next (at a convenient time, ideally as soon as possible after reading the 3 vignettes), you will be asked to verbally respond to the 3 vignettes by providing your assessment of the factitious scenarios and answering questions related to the 3 vignettes in a conversational interview with this nurse researcher. This interview (~1 hour) will also be audio taped.

The researcher may call you for further questions and clarification. You may decline to answer any question or questions.

Risks and Inconveniences

In the process of the interview you may experience some distress in discussing suicide assessment or feel uncomfortable being observed by a nurse researcher, otherwise, there are no other known risks or discomforts.

Benefits

Although the results of this study may not be of direct or immediate benefit to you, the information obtained from the study has potential important implications for nursing practice and education. If nurses can better understand the process(es) by which nurses assess patients, educational opportunities can be designed to facilitate this role. The results can improve care and patient outcomes.

Economic Considerations

None

In Case of Injury

There are no known risks other than perhaps feeling uncomfortable while being observed and asked questions by the researcher and/or some distress in discussing suicide assessment. However, should injury result, there is no formal program for ----- Hospital or the researcher(s) to pay for treatment or injury resulting from this study, or to pay for such things as lost wages, disability, or discomfort due to injury. By signing this form you will not give up any of your rights concerning compensation for injury.

In the event that you need hospitalization for medical or psychiatric care, the study investigators, ----- Hospital, and University of Rhode Island will not assume responsibility for treatment expenses. If your insurance will not pay for inpatient care, you may be at risk for personal financial responsibility for hospitalization.

Alternative Treatments

The decision to take part in this study is up to you. You do not have to participate. If you decide to take part in the study, you may quit at any time. Whatever you decide will in no way affect your job, status in nursing services or job evaluation. If you wish to quit, you simply inform John M. Aflague at ----- or ----- at ----- of your decision.

Confidentiality

You will not be personally identified in any reports or publications that may result from this study. The confidentiality of the information you provide to us will be maintained in accordance with the laws of the State of Rhode Island and Providence Plantations.

The information that you provide will be used for research purposes only, including teaching and publication.

Due to the sensitive nature of the study, consent forms and identifying face sheets will be kept separate from the rest of the study and secured in locked cabinets at the researcher's office as outlined. The listing of your name and assigned code number will be recorded on a separate sheet filed in a locked drawer to whom only the investigator has access. All records, including notes and transcribed interviews, will not identify you by name and will be kept locked in a file cabinet. A code number will identify the interview. Audiotapes will be kept in a separate locked file cabinet. Your name will not appear on the audiotape label. A number, assigned by this researcher, will appear on the audiotape label. Because the audiotapes have intrinsic value for future research, they will be kept in a locked cabinet for three years at which time the contents will be erased by the researcher.

Patient consent forms will not identify the patient as seeking psychiatric services. These forms will be kept locked in a separate locked file cabinet in another location for three years.

Voluntary Participation

You are free to decide whether or not to participate in this study and free to withdraw from the study at any time. A decision not to participate or to withdraw from the study will not adversely affect future interactions with ----- Hospital, ----- University, or University of Rhode Island.

Financial Disclosure

Not applicable.

Questions

In preparation of this consent form it was necessary to use several technical words. Please ask for an explanation of any that you do not understand.

EVERYONE IS ASKED TO SIGN THE FOLLOWING
AND HAVE THEIR SIGNATURES IN THE WITNESS

<p>_____ _____ _____ _____</p>

Authorization: I have read this form and decided that _____
(name of subject)

will participate in the project described above. Its general purposes, the nature of my involvement, and possible hazards and inconveniences have been explained to my satisfaction. My signature also indicates that I have received a copy of this consent form.

R.N. Participant's Signature

Date

Signature of Principal/Other Investigator
John M. Aflague, Ph.D.(c), M.S., R.N., C.S.

Telephone

or

Signature of Person Obtaining Consent

Telephone

If you have further questions about this project or about research-related injuries or if you are not satisfied with the way this study is performed, you may discuss your complaints with John M. Aflague ----- or with his major professor, Dr. Hesook Suzie Kim, Ph.D., R.N., College of Nursing, University of Rhode Island at (401) 874-5329 or ----- at -----, anonymously, if you choose. If you have questions about your rights as a research subject, please contact -----, M.D., Chair, ----- Hospital Institutional Review Board, at -----. In addition, you may contact the office of the Vice Provost for Graduate Studies, Research and Outreach, 70 Lower College Road, Suite 2, University of Rhode Island, Kingston, Rhode Island, telephone: (401) 874-4328.

**THIS FORM IS NOT VALID UNLESS THE FOLLOWING
BOX HAS BEEN COMPLETED IN THE IRB OFFICE**

THIS FORM IS VALID ONLY UNTIL

(date)

IRB PROTOCOL #

INITIALED:

CONSENT FOR AUDIO TAPE INTERVIEW

I, _____, hereby authorize John M. Aflague,

(Registered Nurse Participant)

Ph.D.(c), M.S., R.N., C.S., to make an audio recording of interviews with him on

(Date[s])

I understand that this recording will be used for the sole purposes of research, education, or treatment by properly qualified research personnel and will remain the property of the researcher.

I understand that this recording will be erased when it is no longer to be used for research, education, or treatment purposes (at the end of three years).

I understand that every effort will be made not to identify me by name on the recording.

 Signature of R.N. Participant

 Date

 Signature of Witness

 Date

ERASED:

 Date

 Signature

CONSENT FOR PARTICIPATION IN A RESEARCH PROJECT

(University Affiliated Acute Urban Psychiatric Hospital)

Suicide Assessment by Psychiatric-Mental Health Nurses: A Phenomenographic Study

PATIENT INFORMED CONSENT

Invitation to Participate and Description of Project

You are invited to participate in a study designed to investigate assessment by nurses. You have been invited to participate because you are a patient of your assigned nurse who has consented to participate in this study. Your participation in the study would last *approximately 10 to 30 minutes*.

In order to decide whether or not you wish to be a part of this research study, you should know enough about its risks and benefits to make an informed judgment. This consent form gives you detailed information about the research study which a member of the research team will discuss with you. This discussion should go over all aspects of this research: its purpose, the procedures that will be performed, any risks of the procedures, possible benefits and possible alternative treatments. Once you understand the study, you will be asked if you wish to participate; if so, you will be asked to sign this form.

Description of Procedures

If you decide to take part in this study here is what will happen. Once your questions have been satisfactorily and fully answered, your nurse will obtain your signed and dated informed consent. The nurse researcher will also sign this consent. A copy of the consent will be immediately given to you and a copy placed in your medical record. Your decision (to participate or not) will not effect your care.

Once consent is obtained, this researcher will observe your nurse perform an assessment on you. If you should decide to withdraw your consent or there is a disruption in agency routine (at any time), this researcher will remove himself.

During the observational period, this researcher will be located on the periphery observing your nurse interview you.

Risks and Inconveniences

During the interview by your nurse, you may experience distress or feel uncomfortable being observed, otherwise, there are no other known risks or discomforts.

Benefits

Although the results of this study may not be of direct or immediate benefit to you, the information obtained from the study has potential importance to nursing practice and education. This could improve nursing care.

Economic Considerations

None

In Case of Injury

There are no known risks other than perhaps experiencing distress or feeling uncomfortable while being observed. However, should injury result, there is no formal program for ----- Hospital, The University of Rhode Island, or the researcher(s) to pay for treatment or injury resulting from this study, or to pay for such things as lost wages, disability, or discomfort due to injury. By signing this form you will not give up any of your rights concerning compensation for injury.

In the event that you need hospitalization for medical or psychiatric care, the study investigators, ----- Hospital, and The University of Rhode Island will not assume responsibility for treatment expenses. If your insurance will not pay for inpatient care, you may be at risk for personal financial responsibility for hospitalization.

Alternative Treatments

The decision to take part in this study is up to you. You do not have to participate. If you decide to take part in the study, you may quit at any time. Whatever you decide will in no way affect your care or treatment. If you wish to quit, you simply tell John Aflague at ----- or ----- at ----- of your decision.

Confidentiality

You will not be personally identified in any reports or publications that may result from this study. The confidentiality of the information you provide

to us will be maintained in accordance with the laws of the State of Rhode Island and Providence Plantations.

The information that you provide will be used for research purposes only, including teaching and publication.

The consent form will not identify your seeking mental health services. These forms will be kept in a separate locked file cabinet in the researcher's locked office for three years then destroyed.

Voluntary Participation

You are free to decide whether or not to participate in this study and free to withdraw from the study at any time. A decision not to participate or to withdraw from the study will not adversely affect future interactions with ----- Hospital, ----- University, or The University of Rhode Island.

Financial Disclosure

Not applicable.

Questions

In preparation of this consent form it was necessary to use several technical words. Please ask for an explanation of any that you do not understand.

Authorization:

I have read this form and decided that _____
 (name of subject)

will participate in the project described above. Its general purposes, the nature of my involvement, and possible hazards and inconveniences have been explained to my satisfaction. My signature also indicates that I have received a copy of this consent form.

 Signature

 Date

 Signature of Principal/Other Investigator
 John M. Aflague, Ph.D.(c), M.S., R.N., C.S.

 Telephone

and

 Signature of R.N. Obtaining Consent

 Telephone

If you have further questions about this project or about research-related injuries or if you are not satisfied with the way this study is performed, you may discuss your complaints with John Aflague _____ or with his major professor, Dr. Hesook Suzie Kim, Ph.D., R.N., College of Nursing, University of Rhode Island at (401) 874-5329 or _____ at _____, anonymously, if you choose. If you have questions about your rights as a research subject, please contact _____ M.D., Chair, ----- Hospital Institutional Review Board, at -----. In addition, you may contact the office of the Vice Provost for Graduate Studies, Research and Outreach, 70 Lower College Road, Suite 2, University of Rhode Island, Kingston, Rhode Island, telephone: (401) 874-4328.

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 BOX HAS BEEN COMPLETED IN THE IRB OFFICE**

THIS FORM IS VALID ONLY UNTIL

(date)

IRB PROTOCOL #

INITIALED:

CONSENT FOR PARTICIPATION IN A RESEARCH PROJECT

----- Hospital and University of Rhode Island College of Nursing
(Acute Psychiatric Inpatient Unit in a General Community Hospital)

Suicide Assessment by Psychiatric-Mental Health Nurses: A Phenomenographic Study

R.N. PARTICIPANT INFORMED CONSENT

Invitation to Participate and Description of Project

You are invited to participate in a study designed to investigate suicide assessment by psychiatric-mental health nurses. You have been invited to participate because you are a registered psychiatric-mental health nurse and have been identified by a colleague as being potentially interested in participation. Your participation in the study would last *approximately one day to four weeks*. It will require approximately two to four hours.

In order to decide whether or not you wish to be a part of this research study, you should know enough about its risks and benefits to make an informed judgment. This consent form gives you detailed information about the research study which a member of the research team will discuss with you. This discussion should go over all aspects of this research: its purpose, the procedures that will be performed, any risks of the procedures, possible benefits and possible alternative treatments. Once you understand the study, you will be asked if you wish to participate; if so, you will be asked to sign this form.

Description of Procedures

If you decide to participate in this study here is what will happen. Once your questions have been satisfactorily and fully answered, this researcher will obtain your signed and dated informed consent. A copy of the consent will be promptly given to you. You will complete and return a brief demographic data sheet.

The Attending Psychiatrist will identify patients for recruitment. The Unit Manager or study sponsor will ask potential adult patients' permission for this researcher to observe you interview them. Inclusion criteria for consenting adult patients will be that they are 18 years of age or older, can speak English, and are competent to provide informed consent for observations (i.e., individuals with guardians or who are court mandated will be excluded). Each eligible patient will be informed that the researcher is a nurse studying nurses in practice by observing them for periods of time. Patients will be informed that their decision (to participate or not) will not effect their care or treatment. The Unit Manager, study sponsor, or researcher will also obtain potential patient's initialed and dated consent. This consent will

also be signed and dated by the Unit Manager, study sponsor, or this researcher once the patient's question(s), if any, are fully answered by the researcher. Once patient consent is obtained, this researcher will observe you perform a suicide assessment on one appropriate consenting adult patient. If a patient does not formally consent or there is a disruption in agency routine (at any time), this researcher will remove himself.

During the observational period, this researcher will be located on the periphery observing you interview the patient. As soon as possible following the observation session, this researcher will arrange a conversational interview with you. The conversational interview will be conducted in a private area in the clinical setting or mutually negotiated place away from others to maintain confidentiality, freedom of speech, and provide a conducive environment. During this time, this nurse researcher will ask you to share how you go about performing suicide assessment of patients. The interviews will take place "off duty." This interview (~1 hour) will be audio taped. You understand that every effort will be made not to identify you on the recording(s).

At a convenient time (which could occur on the same day of the patient observation and conversational interview as outlined above and as follows:), you will also be asked to read 3 brief vignettes. Next (at a convenient time, ideally as soon as possible after reading the 3 vignettes), you will be asked to verbally respond to the 3 vignettes by providing your assessment of the factitious scenarios and answering questions related to the 3 vignettes in a conversational interview with this nurse researcher. This interview (~1 hour) will also be audio taped.

The researcher may call you for further questions and clarification. You may decline to answer any question or questions.

Risks and Inconveniences

In the process of the interview you may experience some distress in discussing suicide assessment or feel uncomfortable being observed by a nurse researcher, otherwise, there are no other known risks or discomforts.

Benefits

Although the results of this study may not be of direct or immediate benefit to you, the information obtained from the study has potential important implications for nursing practice and education. If nurses can better understand the process(es) by which nurses assess patients, educational opportunities can be designed to facilitate this role. The results can improve care and patient outcomes.

Economic Considerations

None

In Case of Injury

There are no known risks other than perhaps feeling uncomfortable while being observed and asked questions by the researcher and/or some distress in discussing suicide assessment. However, should injury result, there is no formal program for ----- Hospital, The University of Rhode Island, the researcher(s), or their agents to pay for treatment or injury resulting from this study, or to pay for such things as lost wages, disability, or discomfort due to injury. By signing this form you will not give up any of your rights concerning compensation for injury.

In the event that you need hospitalization for medical or psychiatric care, the study investigators, ----- Hospital, The University of Rhode Island, the researcher(s), or their agents will not assume responsibility for treatment expenses. If your insurance will not pay for inpatient care, you may be at risk for personal financial responsibility for hospitalization.

Alternative Treatments

The decision to take part in this study is up to you. You do not have to participate. If you decide to take part in the study, you may quit at any time. Whatever you decide will in no way affect your job, status in nursing services or job evaluation. If you wish to quit, you simply inform John M. Aflague at -----or ----- at ----- of your decision.

Confidentiality

You will not be personally identified in any reports or publications that may result from this study. The confidentiality of the information you provide to us will be maintained in accordance with the laws of Massachusetts and the State of Rhode Island and Providence Plantations.

The information that you provide will be used for research purposes only, including teaching and publication.

Due to the sensitive nature of the study, consent forms and identifying face sheets will be kept separate from the rest of the study and secured in locked cabinets at the researcher's office as outlined. The listing of your name and assigned code number will be recorded on a separate sheet filed in a locked drawer to whom only the investigator has access. All records, including notes and transcribed interviews, will not identify you by name and will be kept locked in a file cabinet. A code number will identify the interview. Audiotapes will be kept in a separate locked file cabinet. Your name will not appear on the audiotape label. A number, assigned by this researcher, will appear on the audiotape label. Because the audiotapes have intrinsic value for future

research, they will be kept in a locked cabinet for three years at which time the contents will be erased by the researcher.

Patient consent forms will not identify the patient as seeking psychiatric services. These forms will be kept locked in a separate locked file cabinet in another location for three years than destroyed by this researcher.

Voluntary Participation

You are free to decide whether or not to participate in this study and free to withdraw from the study at any time. A decision not to participate or to withdraw from the study will not adversely affect future interactions with -----
----- Hospital or the University of Rhode Island.

Financial Disclosure

Not applicable.

Questions

In preparation of this consent form it was necessary to use several technical words. Please ask for an explanation of any that you do not understand.

Authorization: I have read this form and decided that _____
(name of subject/nurse participant)

will participate in the project described above. Its general purposes, the nature of my involvement, and possible hazards and inconveniences have been explained to my satisfaction. My signature also indicates that I have received a copy of this consent form.

R.N. Participant's Signature

Date

Signature of Principal/Other Investigator
John M. Aflague, Ph.D.(c), M.S., R.N., C.S.

Telephone

or

Signature of Person Obtaining Consent

Telephone

If you have further questions about this project or about research-related injuries or if you are not satisfied with the way this study is performed, you may discuss your complaints with John M. Aflague (617) 325-1732 or with his major professor, Dr. Hesook Suzie Kim, Ph.D., R.N., College of Nursing, University of Rhode Island at (401) 874-5329 or _____ at _____, anonymously, if you choose. If you have questions about your rights as a research subject, please contact _____ M.D., Chair, _____ Hospital Institutional Review Board, at _____.

- In addition, you may contact the office of the Vice Provost for Graduate Studies, Research and Outreach, 70 Lower College Road, Suite 2, University of Rhode Island, Kingston, Rhode Island, telephone: (401) 874-4328.

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BOX HAS BEEN COMPLETED IN THE IRB OFFICE**

THIS FORM IS VALID ONLY UNTIL

(date)

IRB PROTOCOL #

INITIALED:

CONSENT FOR AUDIO TAPE INTERVIEW

I, _____, hereby authorize John M. Aflague,

(Registered Nurse Participant)

Ph.D.(c), M.S., R.N., C.S., to make an audio recording of interviews with him
on

(Date[s])

I understand that this recording will be used for the sole purposes of research,
education, or treatment by properly qualified research personnel and will
remain the property of the researcher.

I understand that this recording will be erased when it is no longer to be used
for research, education, or treatment purposes (at the end of three years).

I understand that every effort will be made not to identify me by name on the
recording.

Signature of R.N. Participant

Date

Signature of Witness

Date

ERASED:

Date

Signature

CONSENT FOR PARTICIPATION IN A RESEARCH PROJECT

----- Hospital and The University of Rhode Island
 (Acute Psychiatric Inpatient Unit in a General Community Hospital)
***Assessment by Psychiatric-Mental Health Nurses:
 A Phenomenographic Study***

PATIENT INFORMED CONSENT

Invitation to Participate and Description of Project

You are invited to participate in a study designed to investigate assessment by nurses. You have been invited to participate because you are a patient of your assigned nurse who has consented to participate in this study. Your participation in the study would last *approximately 10 to 30 minutes*.

In order to decide whether or not you wish to be a part of this research study, you should know enough about its risks and benefits to make an informed judgment. This consent form gives you detailed information about the research study which a member of the research team will discuss with you. This discussion should go over all aspects of this research: its purpose, the procedures that will be performed, any risks of the procedures, possible benefits and possible alternative treatments. Once you understand the study, you will be asked if you wish to participate; if so, you will be asked to initial this form.

Description of Procedures

If you decide to take part in this study here is what will happen. Once your questions have been satisfactorily and fully answered, a member of the research team will obtain your initialed and dated informed consent. The nurse researcher will also sign this consent. A copy of the consent will be immediately given to you and a copy placed in your medical record. Your decision (to participate or not) will not effect your care.

Once consent is obtained, this researcher will observe your nurse perform an assessment on you. If you should decide to withdraw your consent or there is a disruption in agency routine (at any time), this researcher will remove himself. This will not affect your care or treatment.

During the observational period, this researcher will be located on the periphery observing your nurse interview you.

Risks and Inconveniences

During the interview by your nurse, you may experience distress or feel uncomfortable being observed, otherwise, there are no other known risks or discomforts.

Benefits

Although the results of this study may not be of direct or immediate benefit to you, the information obtained from the study has potential importance to nursing practice and education. This could improve nursing care.

Economic Considerations

None

In Case of Injury

There are no known risks other than perhaps experiencing distress or feeling uncomfortable while being observed. However, should injury result, there is no formal program for ----- Hospital, The University of Rhode Island, the researcher(s), or their agents to pay for treatment or injury resulting from this study, or to pay for such things as lost wages, disability, or discomfort due to injury. By signing this form you will not give up any of your rights concerning compensation for injury.

In the event that you need hospitalization for medical or psychiatric care, the study investigators, ----- Hospital, The University of Rhode Island, the researcher(s), or their agents will not assume responsibility for treatment expenses. If your insurance will not pay for inpatient care, you may be at risk for personal financial responsibility for hospitalization.

Alternative Treatments

The decision to take part in this study is up to you. You do not have to participate. If you decide to take part in the study, you may quit at any time. Whatever you decide will in no way affect your care or treatment. If you wish to quit, you simply tell John Aflague at ----- or ----- at ----- of your decision.

Confidentiality

You will not be personally identified in any reports or publications that may result from this study. The confidentiality of the information you provide to us will be maintained in accordance with the laws of Massachusetts and the State of Rhode Island and Providence Plantations.

The information that you provide will be used for research purposes only, including teaching and publication.

The consent form will not identify you by name nor of your seeking mental health services. These forms will be kept in a separate locked file cabinet in the researcher's locked office for three years then destroyed.

Voluntary Participation

You are free to decide whether or not to participate in this study and free to withdraw from the study at any time. A decision not to participate or to withdraw from the study will not adversely affect future interactions with -----
----- Hospital or The University of Rhode Island.

Financial Disclosure

Not applicable.

Questions

In preparation of this consent form it was necessary to use several technical words. Please ask for an explanation of any that you do not understand.

Authorization:

I have read this form and decided that _____

(initials of subject)

will participate in the project described above. Its general purposes, the nature of my involvement, and possible hazards and inconveniences have been explained to my satisfaction. My signature also indicates that I have received a copy of this consent form.

Patient's Initials

Date

Signature of Principal/Other Investigator (obtaining final consent)
John M. Aflague, Ph.D.(c), M.S., R.N., C.S.

Telephone

and

Signature of R.N. (obtaining initial consent)

Telephone

If you have further questions about this project or about research-related injuries or if you are not satisfied with the way this study is performed, you may discuss your complaints with John Aflague ----- or with his major professor, Dr. Hesook Suzie Kim, Ph.D., R.N., College of Nursing, University of Rhode Island at (401) 874-5329 or ----- at -----, anonymously, if you choose. If you have questions about your rights as a research subject, please contact ----- M.D., Chair, ----- Hospital Institutional Review Board, at ----- . In addition, you may contact the office of the Vice Provost for Graduate Studies, Research and Outreach, 70 Lower College Road, Suite 2, University of Rhode Island, Kingston, Rhode Island, telephone: (401) 874-4328.

**THIS FORM IS NOT VALID UNLESS THE FOLLOWING
BOX HAS BEEN COMPLETED IN THE IRB OFFICE**

THIS FORM IS VALID ONLY UNTIL

(date)

IRB PROTOCOL #

INITIALED:

**UNIVERSITY OF RHODE ISLAND IRB
PATIENT INFORMED CONSENT**

I voluntarily agree to have John M. Aflague, Ph.D.(c), M.S., R.N., C.S. observe my nurse interview me. Any questions have been satisfactorily and fully answered. My confidentiality is guaranteed. I understand that I may withdraw my consent at any time.

Signature of Patient:

Date:

Signature of Witness:

Date:

Signature of Researcher:

Date:

John M. Aflague, Ph.D.(c), M.S., R.N., C.S.

Consent form copy ___ participant ___ medical record ___ researcher ___ other

Appendix F: Demographic Data Sheet**Demographic Data Sheet**

Date _____ Date and Time of Interview(s) _____
Name ("Identification" Code Number) _____
Age __ Gender __ Marital Status __ Ethnicity _____ Religion _____
Nursing degree(s) & Year(s) earned _____ Nursing credentials _____
Years of nursing experience _____
Years of psychiatric nursing experience _____
Years of psychiatric inpatient experience _____
Years of community psychiatric experience _____
Years of psychiatric emergency experience _____
Years of psychiatric intensive care experience _____
Years employed in your current position? _____ Full/part-time _____
Title (position) _____
Type of agency practicing nursing _____
Where did you practice nursing previously and for how long? _____
Primary Language: _____
Professional organizations: _____
Experience(s) with suicide: _____
Specify suicide-related education: _____
Specify suicide-related continuing education: _____
Specify additional readings/independent study regarding suicide: _____

Appendix G: Post Assessment Interview Guide

Post Assessment Interview Guide for Observations and Clinical Vignettes

- Q1 What is your general understanding of suicide?
- Q2 How does this (general understanding of suicide) influence you in any way in your assessments of clients for suicidal risk? If so, in what way(s)?
- Q3 How do you think this has influenced your assessment in this case (or vignette)? If so, how?
- Q4 How would describe this client?
- Q5 What was your first clinical impression when you initially saw this client (read the vignette[s])?
- Q6 What is your assessment of this client's status regarding suicidality?
- Q7 How did you determine this client's status regarding suicidality?
- Q8 What is your estimation of risk for suicide in this patient (vignette[s])?
- Q9 What strategies (approaches) did you use in assessing this client's suicidality?
- Q10 What information did you use in assessing this client for suicidality?
- Q11 Did you have a specific rating of this client's suicidality? If so, what is your rating of this client? And, what specific rating system did you use?
- Q12 Was anything difficult about assessing this client's suicidality?
- Q13 If you compare this client's suicidality to other client's, what (if anything) is unique about this case?
- Q14 Is there anything unique about this assessment? (If so, what is different?)
- Q15 What is your level of certainty regarding the accuracy of this assessment?
- Q16 What do you plan to do next? And why?
- Q17 Tell me about your experience(s) with suicidal risk patients?
- Q18 How has your clinical experience influenced you to perform suicide assessment(s)?
- Q19 How has your clinical experience influenced you to perform suicide assessment in this specific case for suicide risk?
- Q20 How has your education influenced you to perform suicide assessment(s)?
- Q21 How has your education influenced your assessment of this case for suicidal risk?

Appendix H: Preliminary Results Summary

Categories	Actual Case	Vignette 1	Vignette 2	Vignette 3
First Participant–Amy				
P01 risks	X	X	X	X
P02 psych.	X	X	X	X
P03 resources	X	X	X	X
P04 listen	X	X	0	X
P05 ask	X	X	X	X
P06 feasibility	X	X	X	X
P07 observe	X	0	X	0
P08 exemplars	0	0	0	0
P09 intuition	0	0	0	X
P10 history	X	X	X	X
P11 sig. others	X	X	0	X
P12 misc.	X	X	X	X
P13 other profs.	X	0	0	0
P14 do/ne	X	X	X	X
P15 individual	X	X	X	X
P16 stories	X	X	X	X
Second Participant–Beth				
P01 risks	X	X	X	X
P02 psych.	X	X	X	X
P03 resources	X	X	0	X
P04 listen	X	0	0	X
P05 ask	X	X	X	0
P06 feasibility	X	X	X	0
P07 observe	X	0	0	X
P08 exemplars	0	X	0	0
P09 intuition	X	0	X	0
P10 history	X	X	X	X
P11 sig. others	0	0	0	X
P12 misc.	X	X	X	X
P13 other profs.	0	0	0	0
P14 do/ne	X	X	0	X
P15 individual	X	X	X	X
P16 stories	X	X	X	X

Preliminary Results Summary (cont'd)

Categories	Actual Case	Vignette 1	Vignette 2	Vignette 3
<i>Third Participant—Carol</i>				
P01 risks	X	X	X	X
P02 psych.	X	X	X	X
P03 resources	X	X	X	X
P04 listen	X	X	0	X
P05 ask	X	X	X	X
P06 feasibility	X	X	X	X
P07 observe	X	X	X	0
P08 exemplars	X	X	0	X
P09 intuition	0	0	0	0
P10 history	X	X	X	X
P11 sig. others	X	X	0	X
P12 misc.	X	X	X	X
P13 other profs.	X	X	X	0
P14 do/ne	X	X	X	X
P15 individual	X	X	X	X
P16 stories	X	X	X	X
<i>Forth Participant—Denise</i>				
P01 risks	X	X	X	X
P02 psych.	X	X	X	X
P03 resources	X	X	0	0
P04 listen	X	0	0	0
P05 ask	X	X	0	0
P06 feasibility	X	X	X	X
P07 observe	X	0	0	X
P08 exemplars	0	X	0	0
P09 intuition	0	0	X	0
P10 history	X	X	0	X
P11 sig. others	X	0	0	0
P12 misc.	X	X	X	X
P13 other profs.	X	0	0	0
P14 do/ne	X	X	X	X
P15 individual	X	X	0	0
P16 stories	0	0	0	0

Preliminary Results Summary Table (cont'd)

Categories	Actual Case	Vignette 1	Vignette 2	Vignette 3
Fifth Participant-Eve				
P01 risks	X	X	X	X
P02 psych.	X	X	X	X
P03 resources	X	X	X	0
P04 listen	X	X	0	0
P05 ask	X	0	0	0
P06 feasibility	X	X	X	X
P07 observe	0	X	0	0
P08 exemplars	X	X	X	X
P09 intuition	0	X	X	0
P10 history	X	X	X	X
P11 sig. others	X	0	0	X
P12 misc.	X	X	X	X
P13 other profs.	X	0	X	X
P14 do/ne	X	X	X	X
P15 individual	X	X	X	X
P16 stories	X	X	X	X
Sixth Participant-Fran				
P01 risks	X	X	X	X
P02 psych.	X	X	X	X
P03 resources	X	X	0	0
P04 listen	X	X	0	0
P05 ask	X	X	0	0
P06 feasibility	X	X	X	X
P07 observe	X	X	0	0
P08 exemplars	X	0	X	X
P09 intuition	X	0	0	0
P10 history	X	X	0	X
P11 sig. others	0	X	0	X
P12 misc.	X	0	X	X
P13 other profs.	0	0	0	0
P14 do/ne	0	X	X	X
P15 individual	X	X	X	X
P16 stories	X	X	0	X

Category Present or Not Present: X=Present; 0=Not Present
Preliminary Category Designations:

P01	risk factors	P09	intuition
P02	associated states	P10	history
P03	resources	P11	significant other(s)
P04	listen	P12	other
P05	ask	P13	professionals
P06	feasibility	P14	done
P07	observe	P15	individual
P08	exemplars	P16	related stories

Appendix I: Discovered Categories of Description

- C01 Reliance on risk factors which are well-established in the literature.
- C02 States commonly associated with suicidality.
- C03 Availability of resources.
- C04 Listen to client.
- C05 Ask about a suicide plan and/or the feasibility of carrying out a plan.
- C06 Reliance on exemplars.
- C07 Reliance on intuition.
- C08 Perceptions of significant others.
- C09 Reliance on other professionals.
- C10 Related stories related to suicide risk.

Appendix J: Results Summary

Categories	Actual Case	Vignette 1	Vignette 2	Vignette 3
First Participant–Amy				
C01 Risk Factors Consistent with Literature	X	X	X	X
C02 States associated with suicide	X	X	X	X
C03 Resources	X	X	X	X
C04 Listen	X	X	0	X
C05 Ask about plan/feasibility	X	X	X	X
C06 Reliance on Exemplars	0	0	0	0
C07 Intuition	0	0	0	X
C08 Perceptions of Significant Others	X	X	0	X
C09 Reliance on Other Professionals	X	0	0	0
C10 Related Stories	X	X	X	X
Second Participant–Beth				
C01 Risk Factors Consistent with Literature	X	X	X	X
C02 States associated with suicide	X	X	X	X
C03 Resources	X	X	0	X
C04 Listen	X	0	0	X
C05 Ask about plan/feasibility	X	X	X	0
C06 Reliance on Exemplars	0	X	0	0
C07 Intuition	X	0	X	0
C08 Perceptions of Significant Others	0	0	0	X
C09 Reliance on Other Professionals	0	0	0	0
C10 Related Stories	X	X	X	X
Third Participant–Carol				
C01 Risk Factors Consistent with Literature	X	X	X	X
C02 States associated with suicide	X	X	X	X
C03 Resources	X	X	X	X
C04 Listen	X	X	0	X
C05 Ask about plan/feasibility	X	X	X	X
C06 Reliance on Exemplars	0	X	0	0
C07 Intuition	0	0	0	0
C08 Perceptions of Significant Others	X	X	0	X
C09 Reliance on Other Professionals	X	X	X	0
C10 Related Stories	X	X	X	X

Results Summary Table (cont'd)

Categories	Actual Case	Vignette 1	Vignette 2	Vignette 3
<i>Forth Participant-Denise</i>				
C01 Risk Factors Consistent with Literature	X	X	X	X
C02 States associated with suicide	X	X	X	X
C03 Resources	X	X	0	0
C04 Listen	X	0	0	0
C05 Ask about plan/feasibility	X	X	X	X
C06 Reliance on Exemplars	0	X	0	0
C07 Intuition	0	0	X	0
C08 Perceptions of Significant Others	0	0	0	0
C09 Reliance on Other Professionals	X	0	0	0
C10 Related Stories	0	0	0	0
<i>Fifth Participant-Eve</i>				
C01 Risk Factors Consistent with Literature	X	X	X	X
C02 States associated with suicide	X	X	X	X
C03 Resources	X	X	X	0
C04 Listen	X	X	0	0
C05 Ask about plan/feasibility	X	X	X	X
C06 Reliance on Exemplars	X	0	X	X
C07 Intuition	0	X	X	0
C08 Perceptions of Significant Others	0	0	0	X
C09 Reliance on Other Professionals	X	0	X	0
C10 Related Stories	X	X	X	X
<i>Sixth Participant-Fran</i>				
C01 Risk Factors Consistent with Literature	X	X	X	X
C02 States associated with suicide	X	X	X	X
C03 Resources	X	X	0	0
C04 Listen	X	X	0	0
C05 Ask about plan/feasibility	X	X	X	X
C06 Reliance on Exemplars	X	0	X	X
C07 Intuition	X	0	0	0
C08 Perceptions of Significant Others	0	X	0	X
C09 Reliance on Other Professionals	0	0	0	0
C10 Related Stories	X	X	0	X

Category Present or Not Present: X=Present; 0=Not Present

Appendix K: Examples of Participant's Verbatim Conceptualizations

First Participant—Amy

Amy	Actual Case	Vignette 1	Vignette 2	Vignette 3
C01 Risk Factors	Were there any suicides in the family?	Has he ever tried to kill himself in the past?	... has now tried to kill herself while hospitalized.	Adolescents are really at risk for suicide.
C02 Associated States	She was a 44 yr. old single ... who had been unemployed ... experiencing financial problems ... needed (ETOH) detox.	... these are all major stressors & I think their kind of stressors put him at risk, um, for suicide.	She was driving intoxicated, lost control of her car, & as a result her 2 children died (loss).	... looking at psychosocial stressors ...
C03 Resources	And she had good social support.	What kind of supports he actually has?	It doesn't sound like she has a lot of social support.	... Does she have lots of friends? Siblings?
C04 Listen	She was very much engaged.	Get him to talk.	0	If she were able to contract for safety.
C05 Plan/Feasibility	I had asked her if she had any thoughts of hurting herself ...	... does he have any kind of plans or thoughts of how he could kill himself? ... access?	She's also been stalk piling her meds &, um, has come to some resolution that she will kill herself ...& maybe has come to some peace with herself that she's going to carry out on her plan.	I think that taking 10 of her mother's Valium® is up there (risk).
C06 Exemplars	0	0	0	0

First Participant – Amy (cont'd)

Amy	Actual Case	Vignette 1	Vignette 2	Vignette 3
C07 Intuition	0	0	0	I usually have a gut feeling (intuition) whether I think, you know, if I'm on target whether I think a patient's very suicidal or not ...
C08 Significant Others	I also had interviewed her friend who brought her in.	I'd also want to make sure I'd bring his friend in ... & if wife were available .. to make sure she came in as well & kind of get what family & friends are saying.	0	Now, I think here's the case where you need to work with the family ...
C09 Other Professionals	I'm always spelling it out to the doctor.	0	0	0
C10 Related Stories	What motivates them to want to live? ... Is their future optimistic?	... find out ... what he had to look forward to life ... problem solve ... strengths.	She doesn't have a future ... agitated & distressed ... calmness.	Did she do this in the house when her, you know, when her parents were around so that people could see her? Did she telephone a friend? ... school ... peers ... hobbies ... grades.

Second Participant–Beth

Beth	Actual Case	Vignette 1	Vignette 2	Vignette 3
C01 Risk Factors	Risk profile (previous history, family history ...)	... he's male, so he's that puts him at high risk ... previous attempts, family ...	... a previous attempt, trying to cut her neck. ... demographic profile.	... first attempt ...
C02 Associated States	Although someone who is like her who could be bipolar could be very impulsive ...	What other vegetative symptoms does he have? ... catastrophic losses.	... not only loss of her children ... is just catastrophic ... loss.	It seems to be an impulsive act ... (suicidal) note.
C03 Resources	She had a kid & she said she would never do it (suicide) to her child ... out- patient therapist.	What type of supports he has outside the house other than his sick wife?	0	I think you've got to do a lot of work with the parents. ...
C04 Listen	I asked her ... was she a cutter?	0	0	I evaluate/assess the meaning of suicidal note(s). I can get more of a relationship with a patient rather than just a clinician sitting there with a check off list.
C05 Plan/ Feasibility	... She had thoughts but no active plan or intent.	Does he have a plan? Does he have, you know, access to the lethality?	I would ask her ... Is she planning on killing herself? ... saving up prescription medicines as a plan ... to kill herself.	0

Second Participant–Beth (cont'd)

Beth	Actual Case	Vignette 1	Vignette 2	Vignette 3
C06 Exemplars	0	He reminds me of that guy we were talking about, the X (University) Professor ...	0	0
C07 Intuition	... what I use is my instinct ... gut feeling.	0	This is instinct.	0
C08 Significant Others	0	0	0	... parents ...
C09 Other Professionals	0	0	0	0
C10 Related Stories	I saw her suicidal ideation as a symptom of her depressive symptoms & as a symptom of her general anxiety that she was experiencing.	He has been working at the same place for 30 yrs. so that he doesn't have a lot of variety in his life & now ... few other options.	People do self injure with no intent of killing themselves. .. She could have just been desperate.	So I see this as a complete lack of coping. ... look at vegetative symptoms ...

Third Participant-Carol

Carol	Actual Case	Vignette 1	Vignette 2	Vignette 3
C01 Risk Factors	... a man with a previous psychiatric history. ...	... Anyone who's a provider & losses their job & the level of responsibility that they & guilt & out of control they feel regarding ... that situation, I think that puts this person, Andrew, at risk.	... the number of intoxicated people that do dangerous things ...	... troubled teens ... young ... naïve ... not realizing how dangerous they can be.
C02 Associated States	... that the specifics related to his medical history &,um, you know, to current stressors.	... you probably need to know a lot more in the sense of his impulsivity.	Also, the consequences that she's dealing with the loss of 2 children ... range of stressors ...grieving ... agitated ... distressed ... calmness. ...	... impulsive, angry ...
C03 Resources	... social support. ... out-patient doctor.	... what kind of support system ... he has a close friend who's concerned.	... outpatient therapist ...	... relationship with parents ... education ...
C04 Listen	It allows me to be a good listener & to hear the areas which either precipitate or, you know, continue chronic suicidal behaviors. ... I tried to listen.	... ask him...	0	... hearing (her) side of the story.

Third Participant—Carol (cont'd)

Carol	Actual Case	Vignette 1	Vignette 2	Vignette 3
C05 Plan/ Feasibility	? OD	... has a plan to suicide.	How frequently the thoughts of taking the pills come up & how long she's been contemplating suicide ...	I would ask her ... ever attempted (suicide) in past?
C06 Exemplars	0	Just hearing other people um, with job loss, you know, it's certainly a complete life change. ...	0	0
C07 Intuition	0	0	0	0
C08 Significant Others	... if his girlfriend was here to ask her impression	... if his friend demonstrated a concern. ...	0	Relationship with parents. Is she's known anybody (peers, etc.) that's suicide?
C09 Other Professionals	... more info... having a sense from Dr. C. who knows him from an outpatient basis ...peer supervision	 the dialogue between the doctor & myself ... problem solving together.	I would want to talk with that (out patient) clinician.	0
C10 Related Stories	... The continuation of a crisis that just hasn't resolved. ... related to his daughter not, ah, wanting to be involved ... legal issues related to his divorce & things going on in Portugal ... culturally diverse ... barriers.	... kind of a preparation of suicide ... how educated (supports are). ... past experiences (impact on) present stressors .. and future behavior.	... disabled ...	... control ... teens ... overwhelmed Insightfulness Her mother's on Valium®!

Fourth Participant—Denise

Denise	Live	Vignette 1	Vignette 2	Vignette 3
C01 Risk Factors	... family history of suicide ...	I think males are higher risk than females.	Oh, she did already try cut- ting her neck in the hospital.	The suicidal note ...
C02 Associated States	... destructive coping ... self-mutilative behaviors ...	... classic hopeless, helpless symptoms.	... she was drunk driving ...	Impulsive, angry.
C03 Resources	... asked if she was able to contract for safety & come to a staff person ...	... whether he has any supports.	0	0
C04 Listen	... from her words.	0	0	0
C05 Plan/ Feasibility	I asked her directly if she were having suicidal thoughts	I'd want to know what his plan is & whether he has access to that plan.	... she saved enough medications.	... access, how planned it was.
C06 Exemplars	0	... classic case. One of the patients I knew	0	0
C07 Intuition	0	0	Just my overall feeling.	0
C08 Significant Others	0	0	0	0
C09 Other Professionals	... look at her chart ...	0	0	0
C10 Related Stories	0	0	0	0

Fifth Participant-Eve

Eve	Live	Vignette 1	Vignette 2	Vignette 3
C01 Risk Factors	... if she, somehow, got into really bad substance abuse	... for some reason it seems the men are the successful suicides.	... she's definitely tried to kill herself ...	... adolescents being such an emotional time of life ...
C02 Associated States	I get a sense of how oriented they are to the future ...	... concrete.	She's lost her children. ... Maybe she's still having (physical) pain.	Has any friends of hers been doing this?
C03 Resources	...her son, the situation with her boyfriend, where she was going to live.	But he does have a friend that's concerned about him ...	... want to know if there was anyone or anything that she did have in her life that ... was positive for her.	0
C04 Listen	... just on hearing her story ...	... how much someone is going to actually reveal.	0	0
C05 Plan/ Feasibility	I will ask about suicidality.	.. he's feeling pretty really desperate to even consider killing himself ...	She's got pain medication.	Is this the first time she's taken her mother's Valium®?
C06 Exemplars	... when I'm assessing somebody new, it kind of, oh this reminds me of such and so and so, somebody before ...	0	Although, now I'm thinking back when I worked in, I did like a partial (hospitalization) & she (another patient) had her stash of meds but wasn't planning to kill herself ...	... just referring in my head back to the adolescents I've worked with & the one's that I've known. ... my daughter looking at me & it was, it just seemed liked I've been there before.

Fifth Participant–Eve (cont'd)

Eve	Live	Vignette 1	Vignette 2	Vignette 3
C07 Intuition	0	... it almost becomes intuitive, it's like second nature.	... the gut is saying, this is not good here. ... you go with your gut.	0
C08 Significant Others	0	0	0	... have to consider the parents & the family.
C09 Other Professionals	I'm used to working on a team & I knew what the other team people ... the conclusions they had come to with her ...	0	... I didn't have to make the decision by myself.	0
C10 Related Stories	... she had been really truly desperate & at her wits- end when she had been suicidal ...	His whole life has been affected ... assessing the whole patient ...	... looking at what does this woman have left to live for.	What else has been going on, not just getting mad at her parents.

Sixth Participant—Fran

Fran	Live	Vignette 1	Vignette 2	Vignette 3
C01 Risk Factors	I look at the genders, ages	A 50 yr. old male ... is at high risk.	She's already made one attempt ...	... adolescents are high suicide risk.
C02 Associated States	He appears to be a real loner ... strange.	... knowing he has a wife ... he can no longer provide for her; losing his health insurance.	... stress of what she's facing... 2 children died.	... she's very angry. ... impulsive. ... left a suicide note.
C03 Resources	... his father ...(residential) placement ...	... he as a wife that's very ill. ... a friend ... try to get him help.	0	0
C04 Listen	Specifically ask him point blank, if he were suicidal.	... talk with him ...	0	0
C05 Plan/ Feasibility	I asked him ... if it were a suicide attempt ...	... he's already thought of .. killing himself, so he already has a plan ...	So, she has a plan & I think she plans on killing herself. ... OD	... she decided she's going to show them (parents) & she took 10 Valium®.
C06 Exemplars	I've talked to people who have made an attempt.	0	Total experience ... People being suicidal. People suiciding.	... you look at the whole thing of what you've learned; ... working with adolescents ... knowing their always at high risk.
C07 Intuition	I go with my gut feeling. ... I have a gut reaction.	0	0	0
C08 Significant Others	0	... go by his friend that brought him in ...	0	.. you get the family in right away.

Sixth Participant–Fran (cont'd)

Fran	Live	Vignette 1	Vignette 2	Vignette 3
C09 Other Professionals	0	0	0	0
C10 Related Stories	Observations ... facial expression, their eye contact, their tone of voice .. functioning?	... the world is coming to a total end & it doesn't look like there's a way out.	0	.. & to her maybe the worse thing (parental limits) that's ever happened to her in her life

Detail Code Descriptions:

- C01 Reliance on risk factors which are well-established in the literature.
 C02 States commonly associated with suicidality.
 C03 Availability of resources.
 C04 Listen to client.
 C05 Ask about a suicide plan and/or the feasibility of carrying out a plan.
 C06 Reliance on exemplars.
 C07 Reliance on intuition.
 C08 Perceptions of significant others.
 C09 Reliance on other professionals.
 C10 Related stories related to suicide risk.

Appendix L: Labeling of Discovered Categories of Description

(C01) RISK FACTORS

(C02) ASSOCIATED STATES

(C03) RESOURCES

(C04) LISTENING

(C05) PLAN/FEASIBILITY

(C06) EXEMPLARS

(C07) INTUITION

(C08) SIGNIFICANT OTHERS

(C09) OTHER PROFESSIONALS

(C10) RELATED STORIES

Appendix M: Sample of Educational Materials Regarding Phenomenography As A Research Method

- *Phenomenography*—qualitative inductive research method
- Sönnemann (1954) coined “phenomenography”
Sönnemann distinguished between Heidegger’s and Jaspers’ schools of psychopathological research & felt that Jaspers’ *phenomenology* should be called *phenomenography* since it was “a descriptive recording of immediate subjective experience as reported” (p. 344).

Phenomenography—advanced in the 1970’s at the University of Göteborg (Sweden) in the Department of Education by Marton, et al.

- *Phenomenology* – similarities, themes
- *Phenomenography* – qualitative differences (& similarities)
- Etymological roots—“*phainomenon*” (appearance) and “*graphein*” (description); literally, “a description of appearances.”
Phenomenography investigates the (finite) *qualitative different ways in which people perceive, experience, conceptualize, & understand various aspects of phenomena.*

Phenomenography studies subjective thinking of participants.

- Assumption—People vary with regard to what meanings they ascribe to phenomena in the world.
- Goal – to describe and categorize existing conceptions and, more generally, “to discover the structural framework with which various categories of understanding exist” (Morton, 1988, p.147).
- Methodological sequence: *familiarization → condensation → comparison → grouping → articulating → labeling → contrasting.*
- Phenomenographic product (most salient) -*description of categories of description.*
- Scientific Rigor/Reliability/Validity:
 - Cogency – theoretical foundation
 - Credibility – truth of findings judged by experts (intersubjective agreement)
 - Auditability – adequacy of information, sequential steps of data collection/analysis, logic, congruence
 - Fittingness – faithfulness to reality, descriptive detail
 - Identification of differences & potential errors in learning/teaching with implications to improve education, practice, & patient outcomes

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