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Exploring Nurses' Experiences of Caring for Patients Following a Suicide Attempt: A Descriptive Phenomenological Study

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Abstract

Background: Caring for individuals after a suicide attempt places substantial emotional and professional demands on nurses and may affect their psychological well-being and clinical practice.

Objectives: This study explored nurses' lived experiences of caring for individuals after a suicide attempt.

Methods: A descriptive phenomenological design was used. Nurses with experience caring for individuals after a suicide attempt were purposively recruited from the emergency and inpatient wards of hospitals in Kermanshah, Iran. Although 10 to 12 participants were initially planned, recruitment ended when data saturation was reached. Data were collected through in-depth, semistructured interviews lasting 60 to 70 minutes and analyzed using Colaizzi's seven-step phenomenological method. The trustworthiness of the findings was established according to Guba and Lincoln's criteria.

Results: Analysis of the interview transcripts yielded 100 initial codes, which were organized into 9 subthemes and 4 overarching themes: Bearing the Burden of Life-and-Death Responsibility; Balancing Compassion with Emotional Self-Protection; Delivering Care Within an Underprepared and Vulnerable Healthcare System; and Spirituality at the Intersection of Hope and Moral Judgment. These findings underscore the emotional, ethical, organizational, and spiritual challenges that nurses face when caring for individuals following a suicide attempt.

Conclusions: Nurses experience substantial emotional strain and professional responsibility when caring for individuals after a suicide attempt. Strengthening organizational support, fostering therapeutic nurse–patient relationships, and providing psychological support may improve nurses' well-being and enhance the quality of patient care.

Keywords: Suicide, Lived Experience, Qualitative Research, Nursing Care

1. Background

Worldwide, suicidal behavior remains a major public health challenge, despite being largely preventable. It encompasses a broad spectrum of behaviors, ranging from suicidal thoughts and self-inflicted injury to suicide attempts and death by suicide (1, 2). Consequently, ongoing international efforts have prioritized suicide prevention as a key component of mental health promotion and mortality reduction (3). However, the true extent of suicidal behavior is difficult to determine because many cases remain undocumented owing to stigma, cultural barriers, and legal constraints in some countries (3).

Iran has a lower reported suicide rate than the global average, estimated at approximately 5 deaths per

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100,000 population (4). Nevertheless, studies have identified an increasing number of suicide attempts and substantial regional variation, reflecting differences in socioeconomic conditions, cultural characteristics, and health care resources (3). Depression, female sex, and other personal risk factors have also been associated with an increased likelihood of suicidal behavior (5). In addition, persistent stigma surrounding suicide may influence how individuals who survive a suicide attempt are perceived and treated within health care services (5).

Caring for individuals who have survived a suicide attempt requires nurses to manage complex physical, psychological, and emotional needs simultaneously (6, 7). In addition to providing immediate clinical care, nurses are responsible for recognizing ongoing suicide risk, providing emotional support, and establishing therapeutic relationships that facilitate recovery (8). These responsibilities can be emotionally taxing and may lead to uncertainty, frustration, helplessness, and psychological distress, particularly when nurses have received limited education or clinical preparation in suicide care (7, 9).

Existing evidence suggests that nurses' perceptions of and responses to suicidal behavior have important implications for the care patients receive (10). Social stigma surrounding suicide may further shape professional interactions, potentially reducing empathy and creating barriers to person-centered care (10). Although suicide prevention has received increasing research attention, relatively little is known about nurses' experiences of caring for individuals following a suicide attempt across different cultural and clinical settings (11). Addressing this gap may provide valuable evidence to strengthen nursing education, organizational support, and clinical practice (12).

2. Objectives

This study aimed to understand the lived experiences of nurses caring for individuals after a suicide attempt (12).

3. Methods

3.1. Study Design and Setting

A descriptive phenomenological approach was adopted to explore nurses' experiences of caring for individuals following a suicide attempt (13). The study was conducted at teaching hospitals in Kermanshah, Iran.

3.2. Participants and Sampling

Purposive sampling with maximum variation was used to recruit registered nurses who had provided direct care to individuals following a suicide attempt within the previous 2 years. Variation was sought in sex, educational level, clinical experience, and ward type. Potential participants were identified through head nurses, ward supervisors, and nursing colleagues. Of the 10 eligible nurses invited, 8 agreed to participate. Although 10 interviews were initially planned, recruitment ceased after 8 interviews because no new concepts or themes emerged, indicating data saturation. Nurse managers and nurses unwilling to continue participation were excluded.

3.3. Data Collection

Data were collected between December 2024 and March 2025 through individual semistructured interviews lasting 60 to 70 minutes, conducted in a private room at the participants' workplace. Interviews began with the question, "Can you describe your experience of caring for a patient who had attempted suicide?" Probing questions, including "How did this experience affect you?" and "Can you provide an example?", encouraged participants to elaborate on their experiences. Interviews were audio-recorded, transcribed verbatim, and supplemented with field notes documenting nonverbal behaviors and contextual observations. Each participant was interviewed only once, and no repeat interviews were conducted.

All interviews were conducted by the first author, a PhD student in nursing trained in qualitative research, who had no supervisory, managerial, or prior research relationship with the participants. The research team held ongoing reflexive discussions throughout data collection and analysis to minimize potential bias. Written informed consent was obtained from all participants, and confidentiality, voluntary participation, and the right to withdraw were ensured throughout the study.

3.4. Data Analysis

Data analysis was conducted concurrently with data collection using Colaizzi's 7-step phenomenological framework (13). The first author coded the interview transcripts, and the coding and theme development were then reviewed collaboratively with the corresponding author until agreement was achieved. A qualitative research expert supervised the analytical

Table 1. Demographic and Professional Characteristics of the Participants

Participant	Gender	Age	Education Level	Work Experience (Years)	Clinical Ward Type
A	M	25	Bachelor's	3	Emergency Department
B	F	27	Bachelor's	4	ICU
C	M	36	Master's	13	CCU
D	F	38	Doctorate	15	Psychiatry
E	M	24	Master's	2	Surgical Ward
F	M	42	Bachelor's	19	Emergency Department
G	F	30	Bachelor's	8	Psychiatry
H	M	31	Master's	9	Psychiatry

process, and MAXQDA 20 facilitated data organization and management.

3.5. Rigor and Trustworthiness

Trustworthiness was evaluated using Lincoln and Guba's framework (14). Credibility was strengthened through prolonged engagement with the data, maximum variation sampling, peer review, and member checking. Dependability was supported by maintaining detailed documentation throughout the study. Confirmability was enhanced through an audit trail and ongoing reflexive discussions to minimize researcher bias, whereas transferability was facilitated by providing rich contextual descriptions and seeking feedback on the findings from nurses who had not participated in the study.

4. Results

Eight nurses aged 25 to 42 years participated in this study. All had prior experience providing care to individuals following a suicide attempt. The sample included both male and female nurses with diverse educational backgrounds and varying levels of clinical experience in psychiatric settings. Participants' demographic characteristics are summarized in Table 1.

Data analysis yielded 100 initial codes, which were subsequently condensed into 9 subthemes and 4 main themes. The 4 main themes were Bearing the Burden of Life-and-Death Responsibility; Balancing Compassion with Emotional Self-Protection; Delivering Care Within an Underprepared and Vulnerable Healthcare System; and Spirituality at the Intersection of Hope and Moral Judgment (Table 2).

4.1. Bearing the Burden of Life-and-Death Responsibility

Participants described caring for patients who had attempted suicide as fundamentally different from routine nursing care because of the constant awareness that missed warning signs or delayed interventions could result in irreversible consequences. This theme reflects the complex responsibility nurses experienced as they attempted to preserve patients' lives while managing uncertainty, fear, and professional accountability.

4.1.1. Living with the Fear of Irreversible Outcomes

Participants reported continuous vigilance and fear of missing signs that could result in self-harm or suicide. Nurses described suicide care as requiring constant observation and anticipation of potential risks, which extended their responsibility beyond routine clinical monitoring. This ongoing alertness created psychological pressure because even a minor oversight was perceived as potentially having life-threatening consequences. "Caring for suicidal patients is inherently different from caring for other patients. These individuals often experience profound anxiety and hopelessness, necessitating more specialized care." (P5)

4.1.2. Existing Under the Shadow of Accountability

Participants reported concerns about criticism, disciplinary actions, and legal consequences following adverse events. Their experiences indicated that responsibility was shaped not only by commitment to patient safety but also by fear of blame and professional repercussions. This perception of accountability intensified emotional pressure during suicide-related care. "I was always afraid that I might overlook something in a patient's condition and then the supervisor would come for an inspection, find a mistake, criticize me, or reprimand me." (P6)

4.1.3. The Emotional Price of Continuous Responsibility

Sustained responsibility and repeated exposure to suicidal crises contributed to emotional exhaustion and psychological fatigue. Participants described difficulty

Table 2. Overview of the Identified Themes and Codes

Main Themes and Subthemes	Main Codes
Theme 1: Bearing the burden of life-and-death responsibility	
Subtheme 1.1: Living with the fear of irreversible outcomes	Fear of harming the patient; fear of patient suicide; constant vigilance toward patient safety
Subtheme 1.2: Existing under the shadow of accountability	Anxiety about blame or punishment; legal concerns and compensation claims; fear of disciplinary action; concerns regarding professional reputation, job security, and financial penalties
Subtheme 1.3: The emotional price of continuous responsibility	Emotional exhaustion; burnout; persistent psychological pressure; difficulty maintaining emotional equilibrium
Theme 2: Balancing compassion with emotional self-protection	
Subtheme 2.1: Therapeutic presence through empathy and human connection	Active listening; emotional support; providing comfort and understanding; respectful and attentive care; building trust and psychological safety
Subtheme 2.2: Emotional Withdrawal and Stigmatizing Reactions	Dismissing patients' feelings; ridiculing emotional suffering; blaming patients for suicidal behavior; ignoring emotional needs; emotional distancing; negative labeling of patients
Theme 3: Delivering care within an underprepared and vulnerable healthcare system	
Subtheme 3.1: Structural vulnerability of the care environment	Staffing shortages; limited resources; inadequate health care infrastructure; lack of essential equipment; overcrowding; unsafe care environments
Subtheme 3.2: Organizational unpreparedness for suicide care	High patient volume and time pressure; inadequate education and training; limited knowledge regarding suicidal behaviors; ambiguity in professional responsibilities
Theme 4: Spirituality at the intersection of hope and moral judgment	
Subtheme 4.1: Spirituality as a source of meaning, hope, and resilience	Encouraging prayer and spiritual support; promoting hope and forgiveness; strengthening resilience through spirituality
Subtheme 4.2: Spirituality as a source of moral tension and stigma	Viewing suicide as sinful or morally unacceptable; religion-based stigma; moral judgment toward suicidal patients; harmful religious interpretations

maintaining emotional balance when professional demands were combined with personal stressors. Consequently, the burden of responsibility gradually shifted from a professional concern to an emotional and personal challenge. "Under the pressure of work and family problems, I find it hard to concentrate on patients." (P7)

4.2. Balancing Compassion with Emotional Self-protection

Participants described suicide care as a continuous balancing act between therapeutic engagement and emotional self-protection. Although empathy and communication were viewed as essential components of effective care, repeated exposure to patients' suffering sometimes led to emotional distancing as a coping strategy.

4.2.1. Therapeutic Presence Through Empathy and Human Connection

Empathy, active listening, and emotional support were considered central elements of suicide care. Participants emphasized that caring for these patients required relational skills beyond physical nursing tasks, underscoring the importance of trust and psychological safety in therapeutic relationships. "Here, empathy is more important than anything else. In other departments, the focus is on physical tasks, but here, 90% of the work is about communication and listening." (P3)

4.2.2. Emotional Withdrawal and Stigmatizing Reactions

Although participants valued compassionate care, emotional exhaustion and personal beliefs sometimes contributed to distancing behaviors and stigmatizing reactions. These experiences illustrate the tension between professional expectations of nonjudgmental care and the emotional challenges nurses face when caring for patients with suicidal behavior. "I've seen colleagues respond without patience, as if suicidal thoughts were the patient's fault." (P6)

4.3. Delivering Care Within an Underprepared and Vulnerable Healthcare System

Participants emphasized that the quality of suicide care was influenced not only by individual nurses' abilities but also by organizational conditions. Limited resources, insufficient preparation, and unclear responsibilities constrained nurses' capacity to provide comprehensive psychological support.

4.3.1. Structural Vulnerability of the Care Environment

Staff shortages, limited resources, and inadequate infrastructure reduced opportunities for therapeutic communication and continuous patient support. Participants perceived that organizational limitations could shift suicide care from a supportive process to a task-oriented response. "One of the biggest challenges is the shortage of staff and resources." (P4)

4.3.2. Organizational Unpreparedness for Suicide Care

Participants described insufficient education and limited knowledge regarding suicidal behaviors as barriers to providing confident care. Lack of preparation increased uncertainty and imposed additional emotional demands on nurses during critical situations. "In many cases, nurses cannot properly communicate with patients due to insufficient knowledge of psychology and suicidal behaviors." (P2)

4.4. Spirituality at the Intersection of Hope and Moral Judgment

Participants described spirituality as a complex experience that could provide emotional support and hope while, in some situations, contributing to moral tension. Importantly, spirituality itself was not viewed as a source of stigma; rather, stigma emerged when spiritual interpretations were associated with judgment toward suicidal behavior.

4.4.1. Spirituality as a Source of Meaning, Hope, and Resilience

Spiritual beliefs were often used as a source of encouragement and resilience. Participants described spiritual support as a culturally meaningful approach that could strengthen hope and provide emotional comfort for patients experiencing severe distress. "I use religious encouragement, such as suggesting prayer and reminding patients that difficult situations can improve over time." (P3)

4.4.2. Spirituality as a Source of Moral Tension and Stigma

Some participants described situations in which religious interpretations contributed to judgmental views of suicide attempts. These accounts reflected the distinction between supportive spirituality and moral judgment, suggesting that culturally sensitive care requires recognizing patients' beliefs without reinforcing stigma. "At times, I think patients who attempt suicide are committing a sinful act." (P5)

Overall, participants experienced suicide care as a multidimensional process involving responsibility for preserving life, emotional exhaustion, professional accountability, organizational limitations, and personal belief systems. Nurses continuously negotiated between compassion and self-protection, hope and despair, and professional duty and personal vulnerability.

5. Discussion

Caring for suicidal patients was perceived as extending far beyond routine nursing responsibilities, exposing nurses to substantial emotional, ethical, and psychological challenges. A central finding of this study was nurses' experience of bearing the burden of life-and-death responsibility. Participants described persistent concerns about missing suicide warning signs or making clinical decisions that could lead to irreversible consequences. These concerns were reinforced by fears of professional criticism, accountability, and legal repercussions. Similar observations were reported by Derblom et al. (15), who described the emotional burden associated with caring for suicidal patients. Collectively, these findings indicate that suicide care places nurses under sustained psychological pressure, underscoring the need for supportive organizational environments that complement clinical competence.

Living with this level of responsibility also influenced how nurses approached their relationships with patients. Participants consistently described balancing compassionate care with the need to protect their own emotional well-being. Although empathy, active listening, and therapeutic communication were regarded as essential to reducing hopelessness and rebuilding trust, maintaining this level of emotional engagement was not always possible. Consistent with Yarborough et al. (16) and Lee et al. (17), supportive therapeutic relationships were recognized as fundamental to improving patients' emotional well-being. However, repeated exposure to suicidal crises and emotional fatigue sometimes resulted in emotional withdrawal, illustrating the ongoing tension between compassionate care and emotional self-protection (16, 17). These findings reinforce the importance of communication skills training, clinical supervision, and psychological support to help nurses sustain therapeutic relationships without compromising their own well-being.

Participants also recognized that providing compassionate, patient-centered care depended not only on individual commitment but also on the health care environment. Consistent with Derblom et al. (15), staff shortages, limited resources, inadequate preparation for suicide care, and heavy workloads frequently constrained opportunities for

comprehensive assessment and meaningful therapeutic communication. As a result, nurses often prioritized immediate physical care, leaving less time to address patients' emotional and psychological needs. These findings highlight the need for organizational investment in workforce capacity, specialized education, and supportive clinical systems to strengthen suicide care.

Finally, participants highlighted the importance of recognizing the spiritual and cultural dimensions of suicide care. In agreement with Khatami and Khodabakhshi-Koolaee (18), spiritual beliefs were viewed as important sources of hope, resilience, and meaning during psychological crises. At the same time, Zamorano et al. (19) emphasized that cultural and religious differences, together with stigma and discrimination, may undermine patients' trust in health care services. Addressing these dimensions through culturally and spiritually responsive nursing education may strengthen therapeutic relationships and support the delivery of holistic, patient-centered care for suicidal patients.

5.1. Limitations

Several factors should be considered when interpreting these findings. Data were collected from nurses in a single clinical setting, which may limit transferability. The analysis was based on self-reported experiences, did not include patients' perspectives, and reflected limited cultural diversity. As a qualitative inquiry, the findings provide contextual understanding rather than broad generalizability.

5.2. Conclusions

Nurses caring for suicidal patients experienced substantial emotional strain shaped by professional responsibility and organizational challenges. Effective therapeutic communication and trust were central to care, underscoring the importance of workplace support, specialized suicide education, and culturally and spiritually responsive nursing practice.

Footnotes

AI Use Disclosure: The authors declare that no generative AI tools were used in the creation of this article.

Authors' Contribution: All authors contributed to the conceptualization of the study. M. S. and A. J. led the study and contributed to data curation, formal analysis, methodology, data visualization, and original draft preparation. A. J., R. J., and M. S. contributed to data analysis. All authors reviewed and edited the manuscript, approved the final version, and agreed to be accountable for all aspects of the work.

Conflict of Interests Statement: The authors have no conflict of interest To declare.

Data Availability: The datasets generated and analyzed during the current study are not publicly available due to confidentiality and privacy considerations, but are available from the corresponding author upon reasonable request.

Ethical Approval: The ethical standards outlined in the Helsinki Declaration were observed. This research was conducted after receiving approval and an ethical code (IR.KUMS.REC.1403.331) from Kermanshah University of Medical Sciences.

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Informed Consent: Written informed consent was obtained from all participants, and confidentiality, voluntary participation, and the right to withdraw were ensured throughout the study.

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