Clinical education

A theory to guide nursing students caring for patients with suicidal tendencies on psychiatric clinical practicum

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ARTICLE INFO

ABSTRACT

Research concerning this issue demonstrates that nursing students initially feared interacting with and caring for patients with suicidal tendencies. However, there is a lack of research, which examines the care that is provided to patients that are suicidal, by nursing students.

The aim of this study was to develop a theory to guide nursing students when caring for patients with suicidal tendencies on their psychiatric clinical practicum. A qualitative approach using Grounded Theory was used. A total of 22 nursing students who had provided care for suicidal patients were interviewed. The core category that emerged from the data was the 'changing of mindsets towards caring for suicidal patients and promotion of suicidal care competencies'. Other key categories linked to and enfolded within this core category were: suicidal risk assessment; protecting patients' safety; and, developing therapeutic communication competencies to advance suicidal care. This study could help fill a theory-practice gap for both psychiatric nursing teachers and students. Nurse teachers could use this theory as a map to help guide students caring for patients with suicidal tendencies and develop nursing students' suicidal care competencies.

1. Introduction

Suicide is a serious public health dilemma worldwide and in Taiwan. In 2016, approximately 800,000 people died by suicide with a global mortality rate of 12.3 per 100, 000 (World Health Organization, 2017). Suicide is the second leading cause of death among 15-29 years-olds (World Health Organization, 2017). Globally, increased suicide rates are reflected in the suicide statistics of Sri Lanka (28.7/100,000 in 2010; 34.6/100,000 in 20015); America (11.5/100,000 in 2010; 12.6/100,000 in 2015); and Taiwan (15.1/100, 00 in 2014; 16.0/100,000 in 2016) (Ministry of Health and Welfare, 2017; World Health Organization, 2017). In Taiwan, suicide was the 12th leading cause of death for all age groups and the second cause for 15-24 years-old (Ministry of Health and Welfare, 2017). Everyone has a responsibility to promote life and prevent death by suicide, including nursing students.

2. Background

In Taiwan, 90% of people that attempt suicide had a psychiatric illness of whom more than 50% are people with depression (Liang and Yeh, 2015). This means that when individuals have been diagnosed with a mental illness, they should be treated early to achieve optimum healing. However, the stigma associated with having a psychiatric illness in Taiwan impacts on the treatment of psychiatric patients and their families (Shiau et al., 2005). According to Liu's study (2007), 10–30% of patients with depression had accepted psychiatric treatment, but only 10–30% of these received continuous treatment. The risk of suicide is relatively high when depression is not treated long-term. In fact, when depression is treatable, some suicides could be prevented (Lee, 2006).

Scholars reported that clinical practice is the most important part of nursing education (Karimollahi, 2012; Moonaghi et al., 2015). However, some studies elucidated that nursing student in Taiwan had raised anxiety levels prior to and during their psychiatric practicum (Huang, 2006; Lin and Lee, 1995). Lin and Lee (1995) explored 23 nursing students' anxiety levels on their psychiatric practicum. Findings revealed that during the first stage of the practicum students felt high levels of anxiety owing to their perceived lack of knowledge about

conversing with patients. Huang (2006) investigated the anxiety levels of nursing students (n = 20) on acute-psychiatric wards and found that the nursing students had moderate anxiety upon their arrival at the psychiatric wards because of an unfamiliar environment (closed wards, safety searches), misconceptions about the first meeting with patients, and fear of doing something wrong. Melorose and Shapiro (1999) explored the perceptions of six nursing students in Canada on their psychiatric practicum. Findings demonstrated that the students were inclined to fear the patients because they thought they might hurt them and they doubted their ability to provide skilled care. Karimollahi (2012) interviewed 13 Iranian nursing students on psychiatric practicum and found that the students were anxious about working in the psychiatric placement because of negative reports from the media.

There is a dearth of research on nursing students' perceptions of suicidal patients. Some studies explored nursing students' knowledge of suicide and their attitudes toward suicidal patients (Kawanishi et al., 2006; Sun et al., 2011). Kawanishi et al. (2006) investigated nursing students' (n = 116) suicide knowledge and attitudes and found that they lacked knowledge about suicide but most of them demonstrated empathy toward suicidal patients. Sun et al. (2011) conducted a comparative study investigating the effectiveness of a 4-h suicide-education programs for second-year student nurses (n = 174) in Taiwan. Results revealed that the experimental group (n = 95) had more advanced knowledge and positive attitudes toward suicidal patients than the control group (n = 79) did.

Two studies, to-date, have explored nursing students care of suicidal patients. Fenstermaker (2006) used a phenomenological study interviewing 24 American students' experience of caring for suicidal patients. Findings illustrated that interviewees: (1) were afraid of the unknown, because they did not know what the suicidal patients might do, and they did not know how to communicate with the patients; (2) wanted to help patients, but doubted their ability to provide nursing care for them; (3) aspired to establish therapeutic relationships with suicide-attempters; however, they experienced the patients' sadness being projected on to them. Scheckel and Nelson (2014) used a phenomenological method to interview 12 nursing students about their experience of caring for suicidal patients. Findings demonstrated that participants: (1) were afraid to care for patients when they knew they were experiencing suicidal ideation and had also attempted suicide; (2) felt that it was difficult to talk about suicide with suicidal patients because suicide is a taboo topic; (3) observed safe suicide prevention strategies being used to meet the needs of suicide patients. However, no study, to date, has used grounded theory to develop a theory to guide nursing students caring for suicidal patients. Therefore, the aim of this study was to develop a theory to guide nursing students on the care of patients with suicidal tendencies on their psychiatric clinical practicum.

3. Methods

3.1. Design

Grounded theory places emphasis on basic social processes and on theory development (Denzin and Lincoln, 2011; Kolb, 2012). The purpose of this study was to explore student nurses' perceptions of the suicide nursing care process on their psychiatric clinical practicum and to develop a substantive theory. Therefore, Strauss and Corbin's method of grounded theory was the most suitable to use.

3.2. Participants

At the beginning of the study, a purposive sampling technique was used to allow emerging concepts to surface. Subsequently, theoretical sampling was used for selecting further participants, Hence, selecting additional participants to collect new understandings, or to expand and refine concepts that have already emerged (Kolb, 2012). This process means that further participants are interviewed to add to the fullness of the interpretations of concepts. For example, when the category 'Suicidal risk assessment' began to emerge from the data, an additional two nursing students who had used the suicidal risk assessment were selected to elicit more concepts relating to 'suicidal risk assessment' until saturation of this category was reached. In total, 22 nursing student participants were interviewed. The criterion for selection assured that participants had cared for suicidal patients for at least five days into their psychiatric clinical practicum.

This study took place in three universities in Taiwan. The nursing students comprised 21 women and one man, aged from 20 to 23 years (n = 22). Over half of them were not affiliated with a religion (n = 12). One participant's relative had attempted suicide. Each student had nursed from 1 to 4 suicidal patients. Nine patients were experiencing suicidal ideations and 13 had attempted suicide. The length of time students provided care for patients ranged from 5 to 20 days.

3.3. Data collection

This study was conducted from November 2016–August 2017 following completion of the psychiatric practicum. Participants that met the criteria were referred by psychiatric nursing teachers. Semi-structured interviews were used to collect the data. Each participant was interviewed once for about 60 min, in a quiet office at a university (n = 10) or by telephone (n = 12) when it was inconvenient for the participants to go to the research office. Interviews were recorded using audio-tape for facilitating analysis. The initial interview guide contained seven themes relating to participants: (1) thoughts and feelings about caring for suicidal patients; (2) carrying out assessments of suicidal patients; (3) interactions with suicidal patients; (4) nursing care of suicidal patients; (5) influencing factors relating to caring of suicidal patients; (6) difficulties encountered during the suicidal care process; (7) reasons why people attempt suicide.

3.4. Ethical considerations

The study was reviewed and approved by a University Human Research Ethics Committee (104–299). First, the psychiatric nursing teachers referred the students. Second, the researcher informed participants about: the purpose of the research; their right to refuse to or withdraw from participating at any time without an excuse; their right to refuse to answer any questions when they did not want to share their experience; the data and how it would be treated anonymously by coded number. Third, the students were invited to sign the consent form if they agreed to participate in this study.

3.5. Rigor

Three methods were used to promote credibility in this study (Lincoln and Guba, 1985). They were: (1) prolonged involvement: the interviewer would have contact with each participant at least three times before the formal interview in order to enhance interpersonal trust with participants; (2) member checks: two nursing students who provided more concepts were selected to scrutinize all case examples, emergent concepts, subcategories and categories of data analysis and to ensure that data analysis were really reflective of their experience; and (3) expert review, two psychiatric nursing teachers, who had experience of GT research reviewed all case examples, emergent concepts, subcategories and categories of data analysis to verify all analyzed data were reliable.

3.6. Data analysis

The process of data analysis involved constantly moving back and forth between inductive and deductive thinking (Strauss and Corbin, 1998). That is, the findings emerged inductively from the gathered interview data to develop a substantive theory and these were verified

deductively by theoretically sampled data and literature. In this study, constant comparative analysis was used (Strauss and Corbin, 1998), which included open, axial and selective coding. The three coding steps are:

(1). **Open coding:** After each participant's data were collected, the research assistant typed the interview record as soon as possible. Then, the main researcher read the transcripts and line-by-line in-vivo coding captured participants' significant statements (meanings units) and then developed concepts. Next, similar concepts were grouped together to develop categories ($n = 12$). Finally, subcategories ($n = 34$) were established according to their properties and dimensions.

(2). **Axial coding:** Each category was linked by use of a paradigm, which included the causal conditions, contextual conditions, intervening conditions, action/interactions and consequences.

(3). **Selective coding:** The core category was identified culminating in the central theme, or story line, of the data. This means that all categories were related to and integrated with the core category. The core category led to the discovery of the basic social psychological processes. Finally, all categories developed a substantive theory.

4. Findings

Twelve categories were generated from the data and a paradigm was used to link each category. The paradigm demonstrated the relationships among categories and helped to develop a substantive theory (Strauss and Corbin, 1998). There are five components in the paradigm: (1) causal conditions; (2) contextual conditions; (3) intervening conditions; (4) action/interactions; and (5) consequences. A substantive theory was then developed entitled: **'A theory to guide nursing students caring for patients with suicidal tendencies on psychiatric clinical practicum'** (Fig. 1). This figure shows that each of the components in the conceptual paradigm interact with other components and the with the core category.

4.1. Causal conditions

The causal conditions represent sets of events or happenings that influenced the phenomenon (Strauss and Corbin, 1998). Participants perceived the importance of being aware of the causal conditions that might lead patients to attempt suicide as this provides insights into the provision of care required. Three categories were generated relating to the causal conditions and these were subsequently reduced to six sub-categories (Table 1).

Participants revealed that the suicidal patients they nursed had suffered painful life stressors such as family, economic and interpersonal-relationship issues. Being unaware of any coping strategies, these stressors stimulated them to become mentally-ill. In addition, they presented with negative thought patterns, such as hopelessness, worthlessness and 'no other way out' of their distressing lived-experiences. Consequently, some developed suicidal ideations, or, attempted suicide such as wrist cutting, overdosing, or burning charcoal. The following two examples illustrate participants' perceptions of the patients' suicidal experiences:

S 21: This man felt enormous stress because his family put pressure on him to study. He didn't know how to cope with the stress, so he developed suicidal ideations.
S 8: The patient felt his life had "no meaning" because his family went bankrupt, father passed away and he got divorced. So much loss. He wanted to relieve his pain and he tried to take his life by burning charcoal.

4.2. Contextual conditions

Specific sets (patterns) of conditions were created by the contextual conditions, thus shaping a set of circumstances, which intersected dimensionally at this time and place, or problems, leading to participants responding via their actions/interactions (Strauss and Corbin, 1998). Two categories and six sub-categories were generated relating to contextual conditions (Table 2).

Participants perceived that the mental health team collaborated in the treatment and care of suicidal patients. They narrated that team meetings were especially effective as they helped them understand deeply the patients and their lived-experiences. They felt the benefits associated with hearing the different members' opinions (psychiatrist, psychiatric nurse, psychologist, social worker, and occupational therapist) on how to provide "best possible" care, as a team, to achieve a more holistic picture of patients. Further, participants perceived that the teaching strategies used by clinical nursing teachers were particularly important as they facilitated the creation of a "nurturing learning environment". All participants agreed they were afraid of the suicidal patients at the beginning because they worried in case they might say or do something to evoke them to attempt suicide. Thus, participants "felt nervous and anxious" when they were nursing them. Moreover, they felt a sense of "powerlessness" when they were providing care to "challenging" suicidal patients. Two narratives follow:

S13: I attended team meetings every week. The members of the team shared information and then made collective decisions about future care to be provided to meet individual patient's needs. I felt this was wonderful. It let me understand the patient and to learn nursing competencies on how best to care for my patient.
S21: I'm afraid in case I use the wrong words when I begin to interact with the patient. I'm anxious in case I bring his mood down and lead him to take his life. Therefore, I'm aware of every word, every sentence I say.

4.3. Intervening conditions

To mitigate or, otherwise alter, the impact of the causal conditions on the phenomenon, there must be intervening conditions. Facilitation, or constraint of the action/interactional strategies taken, within a specific condition occurs through these intervening conditions (Strauss and Corbin, 1998). Two categories and eight subcategories emerged relating to the intervening conditions (Table 3).

Table 3 highlights that four factors facilitated the suicidal nursing care process (1) participants articulated that patients gave them positive feedback, for example, when patients were willing to disclose their experiences to the nursing students and cooperated with their nursing care; (2) when patients had support systems from their family, friends, religions, or other patients; (3) when nursing student participants perceived "they had a positive mindset" toward suicidal patients, for example, they wanted to care for the patients and they had come to "accept them"; and (4) when participants could cope with difficulties that arose, such as, nursing students looking for someone to talk with and nursing students feeling they had been "well prepared" before beginning the practicum. Conversely, four factors blocked the suicidal nursing care process. (1) When patients gave the students negative feedback, for example, some patients rejected them and told them to "go away", a few patients were unwilling to talk about their experiences; (2) a few patients lacked a support system from their family and friends; (3) some nursing students participants' had a negative mindset toward suicidal patients, for example, they saw it as "a stupid behaviour", or "irresponsible behaviour"; and (4) some nursing student participants perceived they lacked the competencies required to provide therapeutic care to these challenging patients, such as, "difficulty in changing patients' suicidal ideations".
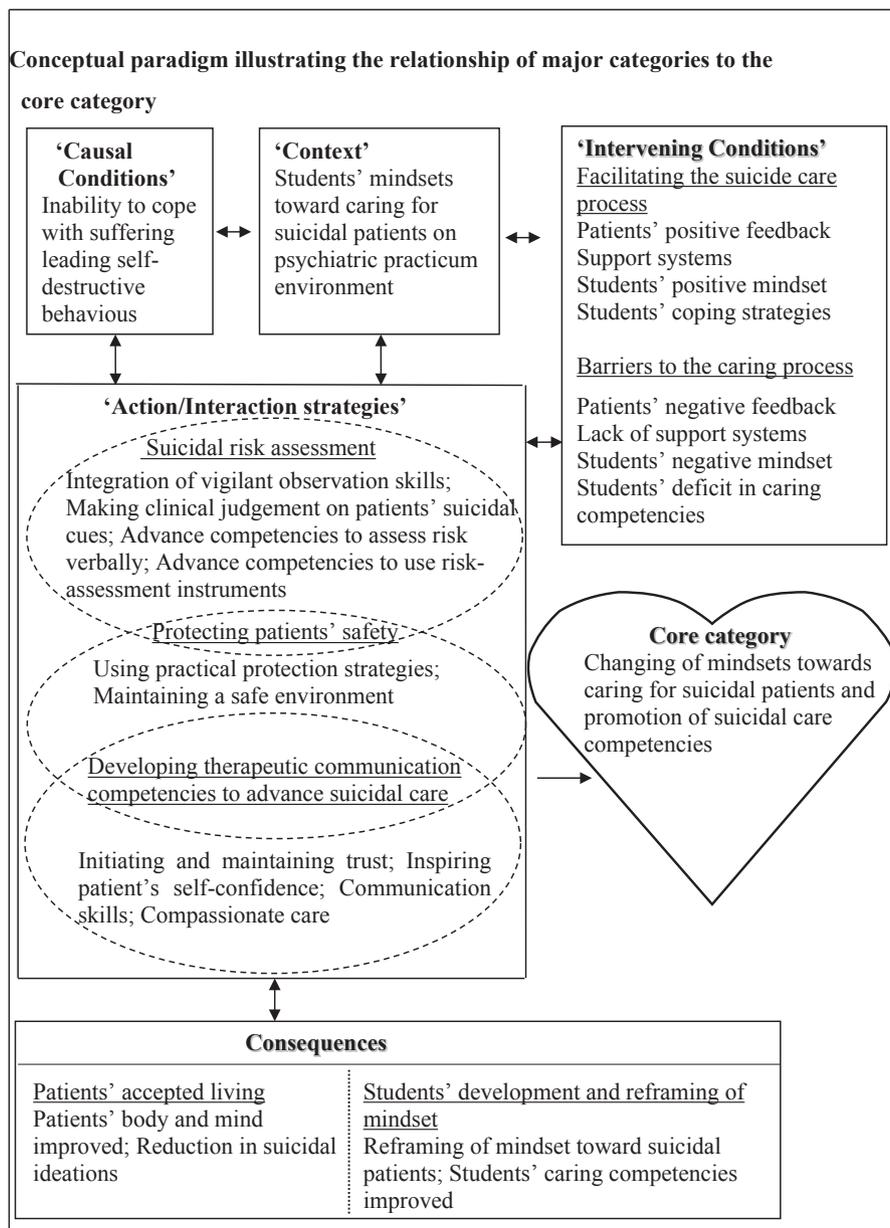
Conceptual paradigm illustrating the relationship of major categories to the
core category

**'Causal
Conditions'**
Inability to cope
with suffering
leading self-
destructive
behaviours

'Context'
Students' mindsets
toward caring for
suicidal patients on
psychiatric practicum
environment

'Intervening Conditions'
Facilitating the suicide care
process
Patients' positive feedback
Support systems
Students' positive mindset
Students' coping strategies

Barriers to the caring process

Patients' negative feedback
Lack of support systems
Students' negative mindset
Students' deficit in caring
competencies

'Action/Interaction strategies'

Suicidal risk assessment

Integration of vigilant observation skills;
Making clinical judgement on patients' suicidal
cues; Advance competencies to assess risk
verbally; Advance competencies to use risk-
assessment instruments

Protecting patients' safety

Using practical protection strategies;
Maintaining a safe environment

Developing therapeutic communication
competencies to advance suicidal care

Initiating and maintaining trust; Inspiring
patient's self-confidence; Communication
skills; Compassionate care

Core category
Changing of mindsets towards
caring for suicidal patients and
promotion of suicidal care
competencies

Consequences

Patients' accepted living
Patients' body and mind
improved; Reduction in suicidal
ideations

Students' development and reframing of
mindset
Reframing of mindset toward suicidal
patients; Students' caring competencies
improved

Fig. 1. A theory to guide nursing students caring for patients with suicidal tendencies on psychiatric clinical practicum.

Table 1
Causal conditions.

Subcategories	Categories
Life events stress	The root of suffering
Distress influencing illness symptoms	
Lack of positive coping skills	Inability to cope with suffering
Repetitive negative thinking	
Suicidal ideations	Self-destructive behaviors
Attempted suicide	

Table 2
Contextual conditions.

Subcategories	Categories
Team collaboration	Creating a nurturing learning
Teaching strategies of clinical nursing teachers	environment
Fear	Students' feelings toward providing
Worry	nursing care for suicidal patients
Nervousness	
Powerless	

S22: I feel if my patient is willing to accept me and trust me, then, he is willing to talk more about his feelings and innermost thoughts. He trusts me which means he approves of my efforts. This affects me and so, I care for him more actively.

S1: My patient speaks, and every sentence is so very negative. I listen to her saying, "I want to die today" and this repetitiveness goes on for days on end. She is having trouble with her family and friends. She thinks they don't understand her. She cannot live in this

world. I don't know what to do when she has this negative thinking all the time.

4.4. Action/interaction strategies

Purposeful, or deliberate acts used, to resolve a problem and to shape the phenomenon in some way are known as action/interaction

Table 3

Intervening conditions.

Subcategories	Categories
Patients' positive feedback	Facilitating the suicide care process
Support systems	
Students' positive mindsets	
Students' coping strategies	
Patients' negative feedback	Barriers to the caring process
Lack of support systems	
Students' negative mindsets	
Students' deficit in caring competencies	

Table 4

Action/interaction strategies.

Subcategories	Categories
Integration of vigilant observation skills	Suicidal risk assessment
Making clinical judgement on patients' suicidal cues	
Advance competencies to assess risk verbally	
Advance competencies to use risk-assessment instruments	
Using practical protection strategies	Protecting patients' safety
Maintaining a safe environment	
Initiating and maintaining trust	Developing therapeutic communication competencies to advance suicidal care
Inspiring patient's self-confidence	
Communication skills	
Compassionate care	

strategies (Strauss and Corbin, 1998). Three categories and ten sub-categories were generated in the action/interaction strategies component of the paradigm (Table 4). During the process of learning about suicidal care, nursing student participants experienced overlapping and dynamic degrees of action and interaction among the three categories.

The three categories were: (1) Suicidal risk assessment: Participants learnt to integrate vigilant observation skills; make accurate clinical judgements on patients' verbal and non-verbal suicidal cues; advance their clinical competence to personally make a risk-assessment of patients, and use suicide risk-assessment instruments. (2) Protecting patients' safety: Participants learnt meaningful protective strategies for patients' safety, such as, closed visits and constant observation of patients; maintaining a safe environment such as protecting patients from dangerous items. (3) Developing therapeutic communication competencies to advance suicidal care: Participants learnt how to communicate therapeutically to initiate and maintain trust as well as inspire patients' self-confidence. They disclosed they had studied competencies and strategies to encourage positive thinking and compassionate techniques to divert patients' minds away from negative thinking. They discovered how to tap into the patients' unique resources, strengths and skills. Three examples follow:

S20: Risk assessment isn't a one-off procedure. I practiced risk-assessing my patient's mood at that moment. Then, I would ask "at what times do you feel like taking your own life? What methods have you thought about? Have you made a plan?" I also used suicidal assessment instrument belonging to the hospital, as a reference to understand the patient's suicide risk.
S12: I would see my patient every 15 min just to observe if she was demonstrating any "strange" behaviors before attempting suicide. I would look for dangerous items on her ward.
S15: I would often talk about the patients' positive attributes with him. For example, I've said; "You're a careful person and responsible person". I'd also invite him to talk about his positive resources.

Table 5

Consequences.

Subcategories	Categories
Patients' body and mind improved	Patients' accepted living
Reduction in suicidal ideations	
Reframed their mindsets toward suicidal patients	Students' development and reframing of mindsets
Students' caring competencies improved	

4.5. Consequences

A consequence that results from the action/interaction strategies is the final paradigm (Strauss and Corbin, 1998). Two categories and four subcategories emerged relating to the consequences (Table 5). They were: (1) patients accepted they were on a healing journey: they began to heal gradually and join in activities, their mood raised, then their suicidal ideations gradually reduced. (2) Students' developed and reframed their mindsets: they became more competent, confident and caring and they used therapeutic communication when interacting with patients. The following two narratives illustrate the positive consequences:

S 19: My patients' auditory hallucinations have improved, they are almost gone. She doesn't hear that voice inside her head telling her to kill herself and she has no suicidal ideations.
S11: Now, I have more empathy for suicidal patients than before. Maybe her desire to commit suicide was related to her illness. I can never say anyone is irresponsible anymore.

4.6. Core category

The central phenomenon is the core category, creating an explanatory whole by connecting all other categories together (Strauss and Corbin, 1998). The current study found that nursing students were afraid of suicidal patients at the beginning of care. However, they reframed their mindsets and developed compassion for patients'suffering. During the care process, students learnt suicidal care competencies from the clinical nursing teachers, the members of team, and patients. Moreover, they advanced their therapeutic communication and their suicidal care competencies. Consequently, the core category that emerged was: **'changing of mindsets towards caring for suicidal patients and the promotion of suicidal care competencies'**. The following example depicts this finding:

S15: When I begin caring for my patient I'm no longer afraid. Before, I misunderstood suicidal patients. Now, I try to understand his suffering and show more empathy and compassion for him. I'm willing to care for suicidal patients in the future.

5. Discussion

The components of the paradigm model illuminate how nursing students, on their psychiatric clinical practicum, defined some of the complex relationships that exist among the suicide care process (Fig. 1). Findings illustrate the importance of preparing student nurses for caring for patients at risk of suicide, on their psychiatric clinical practicum. This study developed '**A theory to guide nursing students caring for patients with suicidal tendencies on psychiatric clinical practicum**' and this theory could be used by clinical psychiatric nursing teachers as a guide to teach and support students on their nursing journey.

In relation to the causal conditions, findings revealed that the main reason why patients attempt suicide is because they cannot cope with their suffering. This finding supports literature (Sun et al., 2006; Vatne and Nåden, 2016). Before working on this psychiatric practicum,

students could not understand why people attempt suicide. During the practicum, they approached suicidal patients and learnt to have compassion for their suffering. Consequently, the nursing students considered it important to learn how to cope with distress and suffering. Vatne and Nåden (2016) reported that suicidal patients will struggle for life when they can cope with their suffering.

Findings from the current study revealed that psychiatric environments were different from other medical wards because they were closed wards. The importance of team collaboration was emphasized. Each mental health team member provided different insights into the holistic treatment and care of individual suicidal patients. These findings support those of Polo et al. (2012). Further, most of the students in this study were afraid of talking about the topic of suicide to their suicidal patients because they worried this might prompt patients to attempt suicide. It is important, therefore, to teach nursing students to change their mindsets on this form of assumption (Lin, 2004). Inviting patients to talk about their attempted suicide helps nursing students make an accurate assessment of risk and could help patients reduce their suicidal ideations.

In relation to the intervening conditions, the most important factor generated was patients' positive feedback. The nursing students felt a sense of accomplishment when the patients began to trust them and talk with them about their negative thinking and their suffering. Chien (2006) reported a sense of accomplishment was a key factor in helping nursing students like their clinical practicum and enrich the care experience for patients. Inversely, the current study found that the students felt a sense of frustration when the patients provided negative feedback, for example when patients did not want to talk about their suicidal ideations. Sun et al. (2006) suggests that if nurses could build a trusting relationship with suicidal patients, they would give the information the nurses need. Therefore, the clinical nursing teachers could help the nursing students to build a trusting relationship with suicidal patients. Moreover, the students felt a sense of powerlessness when encountering challenging patients who were reluctant to change their negative thinking or suicidal ideations. Clinical nursing teachers have a role to play in supporting students' frustrations and helping them understand it takes time for patients' suicidal ideations to change.

In relation to the action/interaction strategies, the nursing students learnt three main strategies when caring for suicidal patients. First, students acquired competencies in the assessment of risk of suicide: assessing suicidal cues, therapeutic communication, using suicidal risk-assessment instruments (Runeson et al., 2017). Clinical nursing teachers could teach students how to use evidence-informed instruments to assess the risk of suicide. Second, students accomplished strategies to protect patients' safety. They attained competencies in skilled and sensitive observation of: patients' mood and any changes in behavior pattern such as the hiding of dangerous items. These findings support research that indicates patients' safety can be protected by close observation and careful monitoring (Imboden and Hatzinger, 2015; Sun et al., 2006). Third, they learnt how to communicate therapeutically, which could be the fundamental key to providing optimum care. Key competencies in communication were to take time and listen empathetically to patients. This engendered the trust required for the formation and development of therapeutic relationships. These findings support those of Sun et al. (2006) who demonstrated that listening and, most important, hearing were important competencies to have when communicating with suicidal patients because they helped develop empathy and compassion.

In relation to the consequences, team care and including therapeutic nursing care helped improve patients' conditions and reduced their suicidal ideations. During the care of suicidal patients, the students reframed their mindsets toward patients because they learned to understand painful lived experiences, coping and suffering. It is very important that nurses have positive and open mindsets toward suicidal patients because nurses' mindsets further impact on their competency to conduct suicide risk assessment and impacts of care (Jones et al., 2015;

Saunders et al., 2012). At the end of psychiatric clinical practicum, the nursing students' suicide care competencies had advanced. Their therapeutic communication competencies had developed a lot. For example, at the beginning they were afraid to talk with patients about their suicidal ideations, but they could, at an appropriate time, talk with patients about their suicidal ideations. Making the clinical judgement about when the time was appropriate is an advanced therapeutic competency. These findings corroborate those of other researchers, which highlighted that communication skills help nurses to understand patients' thoughts and feelings (Goh et al., 2016; Sun et al., 2006).

6. Limitations

There were two major limitations in this study. First, it was difficult to enroll nursing students who had cared for suicidal patients on their psychiatric practicum because only a few nursing students chose to work with suicidal patients as they found them more difficult to work with than other psychiatric patients. Second, only one male nursing student attended this study because the male to female ratio of registered nurses is one to 40 in Taiwan (Taiwan Union of Nurses Association, 2017).

7. Conclusion

The findings that emerged from this study were grounded in the nursing students' insights into caring for patients who had suicidal ideations and/or had previously made suicide attempts, on their psychiatric practicum. A theory that illuminates student nurses' insights into the suicide care process on psychiatric practicum was generated from the findings and this theory is the first of its kind. The theory details the students' perceptions of the suicide care process on psychiatric practicum including the: causal conditions; contextual conditions; intervening conditions; action/interactions strategies, and consequences. Therefore, the findings could be used by clinical nursing teachers as a guide to teach nursing students on the nursing care of suicidal patients.

Author contributions

Study design: FKS; data collection and data analysis: FKS and MHC, and manuscript preparation: FKS, AL, and CYC.

Conflicts of interest

None.

Acknowledgements

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