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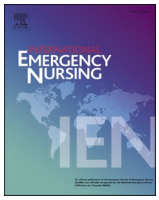

The experience of being in acute emergency care following an overdose with suicidal intent: A hermeneutic phenomenological study

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ABSTRACT

Introduction: Nurses working within Emergency Departments are frequently required to care for individuals impacted by suicidal behaviour.
Literature Review: Published research into the experience of such individuals in emergency care, is limited. Studies identified do not distinguish between self-harming and suicidal behaviour and do not reveal the lived experience in depth.
Aim and Methodology: This research reveals the lived experience of being in emergency care following an overdose with suicidal intent, through the collection of data while patients are still in hospital. Sixteen semi-structured interviews were conducted with patients on a medical admission ward. The research uses an interpretive hermeneutic phenomenological approach.
Analysis: A thematic analysis indicated six key themes: The fear of death and dying, The hospital - a place of safety, Loved ones a reason to live, Feelings of hopelessness, Eclipsed as a suicidal patient, and the Impact of human relationships.
Discussion: The findings are discussed and contextualized within wider literature: The fear of death, hopelessness, the role of stigma and shame, including anticipatory stigma, and the impact of kindness and relationships. Implications for practice are outlined, informing how care can be enhanced by nursing staff.

1. Background

Around 220,000 episodes of suicidal and self-harming behaviour are managed by Emergency Departments each year in England [1]. Evidence suggests that for individuals in crisis, 'Emergency Departments have … become a default pathway to manage people' [2, p.23]. Da Cruz *et al.* [3] calculated that 43 % of people who died by suicide in the Northwest of England, had attended their local emergency department within the past 12 months. The Department of Health and Social Care [4] continues to identify emergency departments as key sites where people in crisis attend, acute emergency care having a vital role in the prevention of suicide.

Research suggests that the experience of individuals attending emergency care following suicidal behaviour is frequently negative. Taylor's *et al.* [5] systematic review highlighted, 'inappropriate staff behaviour and a lack of staff knowledge'. Participants perceived that they were treated differently by staff due to their self-harming/self-poisoning behaviour, describing the experience as frightening. Patients were subjected to threats and humiliation. Such findings were reflected by MacDonald *et al.* [6] who noted a range of 'hostile encounters with clinicians', patients feeling that they were on a 'production line' or were 'a lump of meat'. Such findings were also reflected in Hughes' *et al.* [7] study of patient's experience of attending ED. Patients perceived that they were a low priority, staff expressing 'impatience or annoyance' [7, p.12], enhancing feelings of worthlessness.

Conversely, positive experiences were associated with participants feeling that staff were 'genuinely concerned about them, respected them and did not try to belittle them' [5, p.108]. Positive care associated with gentleness and compassion [6] and expressions of kindness [8].

In seeking to reveal the lived experience of being in emergency care, following suicidal behaviour, these studies, contain several limitations. All the studies combine without distinction, two types of behaviour: self-harm and suicidal. As Muehlenkamp [9, p.23] notes: 'Researchers and clinicians have argued that there is an important distinction between suicidal and non-suicidal self-injurious (NSSI) behaviours for some time and it is now largely accepted that NSSI is different from suicidal

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behaviour.' NSSI is normally a means of coping with life, rather than ending life.

Furthermore, Taylor's *et al.* [5] and MacDonald's *et al.* [6] systematic reviews, incorporated the experience of participants from a large variety of clinical services and countries, with different cultures and health care systems. Studies also focussed on the experience of clinical care, rather than the whole lived experience, with Taylor *et al.* [5] including the views of family and friends alongside patients without distinction. None of the studies identified, captured participant's lived experience while in hospital, with data collection taking place following discharge. The longer the period between the data collection, and the phenomenon being explored occurring, the greater the capacity, for the accounts to be different from the first lived experience [10].

1.1. Aims

The aim of this study was to provide an in-depth account of the lived experience of being in emergency care following an overdose with suicidal intent, collecting data from inpatients, within 48 hours of admission. The study sought to capture the wholeness and richness of that experience, while acknowledging that 'lived life is always more complex than any exploration of meaning can reveal' [11, p.18].

2. Methodology

A hermeneutical phenomenological approach was adopted. Phenomenology seeks the lived experience of a given phenomenon as accurately and as authentically as possible, conveying its structure and its character as it appears in the person's consciousness, in that moment lived [12]. This study is hermeneutical in nature as it seeks the meaning of the phenomenon for the participants, acknowledging that their perception is their reality.

2.1. Ethical approval

Ethical approval for the study was received from the University of Central Lancashire and the Health Research Authority.

2.2. Method and data collection

A purposive sampling method was adopted. Nursing staff, independent from the research team, approached patients on eight randomly selected days, in an hospital in England, who had been admitted via ED, following an intentional overdose with suicidal intent. All patients invited to participate were assessed to have mental capacity by nursing staff. Potential participants were considered physically well enough to participate by medical staff. 19 patients were invited to participate, 17 gave informed consent. Table 1. Despite no distinction being made as to the substance used within the overdose in terms of recruitment, by chance, all participants included had taken an overdose with paracetamol.

The 17 interviews were conducted in a 'quiet room' located on the ward, or at the patient's request, at their bedside. No family or friends were present. 1 interview was terminated by the researcher for ethical reasons and the data excluded. Of the 16 interviews completed, 6 participants agreed to have the interview recorded and 10 participants requested notes to be taken. The mean length of interview was 32 min.

2.3. Analysis

Following transcription, a thematic analysis of the interviews was conducted based on van Manen's [11] three stage approach to holistic, selective, and detailed reading, with the aim of conveying the participants' lived experience. The aim, to bring to the fore the individuals experiences, their perceptions, and associated meanings. Table 1.

2.4. Reflexivity

Heideggerian hermeneutical phenomenology positions the researcher in the study and therefore seek to make the researcher explicit but fostering critical self-awareness through reflexivity [13]. Within this study, reflexivity was practised through keeping a reflexive journal and regular discussion between authors, including in the review of the literature, the research approach adopted, interviewing, analysis, construction of themes and the final paper. The first author carried out the research under supervision from the other authors.

2.5. Findings

Six key themes were developed from the participants interviews, each with four subthemes, as outlined in Table 2. The titles of the themes were chosen to express both the content and the emotion of the participants' lived experience. Table 3.

Table 2
Semi-structured interview topic guide.

Participant's experience of being in ED
Participant's experience of the admission ward. Participant's experience of clinical staff encountered. Participant's experience of mental health assessment if undertaken. Participant's experience of their medical care.

Table 1
Data collection and analysis.

Stage 1 Data collection July – September 2019	19 potential participants approached by nursing staff on admission ward and invited to participate.	Informed consent obtained from 17 participants by researcher 1.	17 interviews conducted on ward by researcher 1, with 48 h of admission. 1 interview terminated.	Sixteen interviews transcribed and upload to NVivo and shared with authors 2 & 3.
Stage 2 Thematic analysis [11] A nonlinear approach of becoming immersed within the transcripts over a 9-month period	Holistic reading of each transcript to locate overall meaning of the text.	Selective reading of key statements and key phrases identified.	Detailed reading of each sentence, asking what each sentence is expressing about the experience	Recurring and intense experiences were identified and brought together using phrases and statements under thematic headings, to convey lived experience and make recommendations.
Stage 3 Reflection (10-month period)	The process of writing and rewriting to reflect on and explore the embodied meaning, constantly returning to the transcripts.	Monthly meetings with authors 2 and 3 to explore, discuss and question themes identified and meanings.	List of themes and sub themes agreed between researchers – See Table 2 below.	

Table 3
Key themes and subthemes.

Key theme	Sub theme	Example quote
Fear of death and dying	Realisation that I could die Wanting to live Wrestling with the fear of death Witnessing death of others changes perspective	'It was just like, panic, I panicked, I thought I was going to die. I panicked; you know.' 'I definitely won't be here again, no, this was the first time and there won't be another, it shocked me.' 'I will do it, I have got to, I can't just keep coming back in here again and again. But it does scare me, ending my life'. 'I saw someone dying, makes you think, it was horrible and frightening. It gives you the determination to try and sort your life out.'
The hospital as a place of safety	Saved by medical intervention A place to be protected from yourself A place of calm A place to think and decide	'They have been really good … regularly coming to take my blood pressure, that made me feel safe. It reassures you that you will get out of where you are now' '… the best way I can put it is that in here your hand is not on the trigger of the gun …' 'Here it is quiet, steady, makes me feel more relaxed here, less anxious…' 'It also gives you a chance to think, give you a moment if you see what I mean, but I am not saying what I have decided.'
Loved ones, a reason to live	The love of family changes perspective Not wanting to leave loved ones Witnessing loved one's reactions Awareness of the impact of their death	'…my dad started crying, it really shocked me. He said he was crying because he was so pleased that I was going to try and get the help…' 'Mother was in my mind, and I was like, I was just closing my eyes and thinking of her, and I blanked out. It made me think about my mum more now…' 'Seeing my family upset when they saw me in hospital, the way they were looking at me …' 'If I died, it would hurt people, they would be upset, especially my dad and my sisters, this is really hard, but I need to try it for them…'
Feelings of hopelessness	Rejection by mental health services Negative perceptions of mental health assessment Inevitability of future suicidal behaviour It felt different if this was the first admission	'They have promised for years that they will give me a psychiatrist, but I have never seen one.' 'I think it will be the same outcome again, … I will just get discharged, it's the same stuff every time.' My mental health crisis is still the same as I won't be getting the help I need; I will be back in here at some point soon or dead. 'I am just waiting to see mental health and then I can get some help and get better.'
Eclipsed as a suicidal patient	Feeling exposed, judged and in danger Feeling dismissed and ignored Feeling angry at staff and the system Feelings of being abandoned	'You feel like everyone is looking at you, like everyone knows. … they would be thinking what has she done, look at her, like they were judging me.' 'I was trying to tell her that I couldn't breathe! I felt like she was not listening to me, like all my problems were mental health…' 'She was horrible, it made me feel horrible, agitated, wanted to punch her…' '…they seem to talk to everyone else; they just give you the medicine and then they walk away. I think I get treated differently because what I have done.'
The impact of human relationships	Positive impact of human kindness Positive impact of not being judged Being surprised by kindness and compassion Feeling undeserving of staff's time	'The A&E staff were very nice, very chatty which makes you forget about why you are there and makes you feel better…' 'The most important thing is just to be treated like everybody else, not judged, don't treat me differently, they haven't…' 'I still feel awkward about it, I just sit here and think when they are nice and stuff, oh God, what do I do.' 'I just draw the curtains around me when I am on the ward and try to keep quiet, out of the way so not to bother them.'

2.6. The fear of death and dying

All participants described a sudden fear of death and dying in ED.

> 'I was really scared, scared about what had happened, what was going to happen, scared that I was not going to be ok'.

Another participant described how the thought of death and dying 'engulfed' them in fear when in ED. It was 'the most terrifying thing ever'. Participants consistently associated the fear of death and dying with the physical symptoms of vomiting:

> 'At one point I was being sick a lot after they put the thing up (intravenous fluids) and it was making me really sick, and I got really worried then. It was just like, panic, I panicked, I thought I was going to die. I panicked; you know. … Reality hit me'.

The fear of death for all the participants, was also associated with the physical space of ED:

> 'I was scared, scared about what was going to happen and why was I in here, if I was going to be alright … scared that I would not be okay. Scared!'

This fear continued on the admission ward: 'To be honest, I am still scared.' Many participants sought 'reassurance' from clinical staff that they were going to be 'ok' and valued staff 'constantly checking' on them. 'I just want them to reassure me that I can go home, and everything is going to be fine.'.

The fear of death caused some participants to seek life and help: 'I think it has been a scary enough experience to make sure I don't go that far down again'. Other participants however, described a continuing struggle to overcome the fear of death, so that they may end their life.

> 'Part of me wants, wants to get better, and part of me is upset that it didn't work. I was also angry with myself for what I had done, angry that I had done it and also scared that it might still work. Part of me wants to kill myself and part of me doesn't, part of me wants to feel safe. It does scare me ending my life'.

2.7. The hospital as a place of safety

Participants valued the hospital as a place of safety where they could receive medical help:

> 'When you take the tablets you know you have made a massive mistake, that you shouldn't have done it, it's scary, you know you need to be somewhere safe to be helped'.

The hospital offered protection from further suicidal behaviour and impulsive actions:

> 'When you are in hospital you feel safe, when you are on your own your mood can change at any time, but here there is that safety net. … the best way I can put it is that in here your hand is not on the trigger of the gun, that is how I would describe it'.

This experience of safety was associated with the presence of the staff. 'I don't trust myself outside, so being in here is safe. Just knowing that they are there and that makes me feel safe'.

2.8. Loved ones a reason to live

Participants described thinking about their loved ones in ED and the impact of their suicidal behaviour: 'My mother was in my mind, and I was like, I was just closing my eyes and thinking of her …'. Several participants described being shocked to experience that their loved ones valued them: 'I had always had it in my head that no one would be really bothered if I went, but seeing them and the way they were, made me realise that they cared.' The experience seemed to cause them to feel a valuing of their loved ones: 'they are the most important people in the world for me. I don't want to die and leave them.' Participants describing an awareness of the impact of their suicidal behaviour: 'When I felt it kicking in, I started to think about my family and everything else, what I was putting them through and how this would affect them.'.

2.9. A feeling of hopelessness

Many participants perceived that future suicidal behaviour or death was inevitable: 'I don't feel like I have got a future as nothing is ever getting better, there is no hope'. 'I feel I will be here again, not next week, but next month or just after, or dead'. Only participants for whom this was their first hospital admission were hopeful about their future. This perception related to a belief in their ability to receive help from statutory mental health services: 'I am just waiting to see mental health and then I can get some help and get better.' In contrast, participants who had attended hospital before, due to suicidal behaviour, expressed feelings of hopelessness. 'Many many many times I have tried to get help but, in the end, you just come back to stage one, and you end up going through it all over again.' 'They told me that there was nothing they could do for me except therapy and then they didn't give me therapy, they just stopped giving me appointments.'.

Participants shared negative perceptions of the mental health professionals who visited them in the hospital. They perceived this as a 'tick box exercise'. They 'read the usual list of questions', announce the word 'safe for discharge' and leave. 'Mental health don't do anything, they just say right, discharge you!' Participants sought a variety of different forms of help, including, medication review, therapy and admission. They perceived however, that they were powerless to access it.

2.10. Eclipsed as a 'suicidal patient'

Some participants described how they perceived that they were treated differently by staff due to their intentional overdose and anticipated this. 'I just felt like everyone was watching me and I couldn't relax, felt like people were judging me.' Such perceptions impacted their sense of worth: 'It made me feel rubbish, rubbish, worthless'. Participants regularly used the word 'exposed' to describe their experience in ED, 'everyone looking at you, like everyone knows … think what has she done', people 'walking up and down … looking at you'.

Several participants stated that they were not listened to by staff due to their suicidal behaviour: 'all she could see was that label'. One individual stated that she was lied to: 'If I needed diazepam and if she told me that she was going to give it me, I would have taken it. She said she was giving me an antibiotic.' Another participant associated perceptions of judgement, with a feeling of abandonment: '…they just give you the medicine and then they walk away. I think I get treated differently because what I have done. They don't like it.' 'I feel like an animal in here or a caged bird, they give you the food to keep you alive and the water and that's it.'.

2.11. The impact of human relationships

When participants described moments of kindness with staff, it frequently evoked strong emotions, including tears. Perceptions of kindness were related to encounters with staff who expressed empathy:

> 'The doctor and the nurse that looked after me were really nice, the nurse especially. She said that she had been through similar things and if I ever needed to talk, to ask. That one thing that she said was better than all the counsellors that have been to the house, it made me feel like I was not alone, and someone cared.'.

Kindness produced hope for several participants: 'Yea it makes you feel a lot more positive and makes you think about talking and stuff. This is not the only way'. 'Makes you feel like someone is there for you and you are going to be alright.' Kindness was experienced in a variety of ways, including an offer to talk, a willingness to listen, short words of good luck, staff sharing their own personal struggles, staff remembering their name.

3. Discussion

An important finding of this study is that participants experienced a sudden and powerful fear of death and dying within ED, a removal of the veiling of Being-towards-death, the greatest disturbance to Dasein [14]. Death is no longer something to be thought about but was being experienced. Shneidman [15, p.3] identifies the fear of death as a 'commonality' in suicide. Likewise, Joiner *et al.* [16] highlights the fear of death as an instinctive protective factor, that is experienced in the moments following suicidal behaviour. This study highlights how such fear of death is also present for individuals in ED.

The perception of hopelessness within this study, is also reflected within wider research. For example, Beck *et al.* [17] evidenced the presence of hopelessness as a strong long-term indicator of death by suicide. Indeed, this scale and concept of hopelessness is a common influence of mental health risk assessment. Drawing on Snyder's [18] theory of hope, the findings of this research show that all the participants had positive goals for the future, for example wanting to return to work. They also perceived a pathway to achieving these goals, this being associated with accessing support from mental health services. Hopelessness, however, was related to a perceived lack of ability to embark on that pathway, a lack of agency. Interestingly, all the participants perceived that the *only* pathway to achieving their goals of feeling better, was associated with receiving support from the statutory mental health service. Such findings reflect wider research evidencing a strong association between feelings of interpersonal dependency and suicidal behaviour [19]. The participants focus on mental health support, was on NHS mental health services, without considering the wider mental health services in third sector organisations. It seems that participants were unaware of these services.

Some participants also experienced stigma and shame. Rayner *et al* [20] in their *meta*-analysis reported that staff in emergency settings, have reported negative opinions towards patients affected by self-harming, including suicidal behaviour. Saunders *et al.* [21], p.207] in their systematic review of staff attitudes around self-harm and suicidal behaviour, noted common feelings of 'irritation and anger'. Likewise, Briggs [22] reported that 40 % of nurses disclosed negative attitudes towards people who are suicidal. In contrast, in their *meta*-analysis of

emergency department staff attitudes towards people who self-harm (including suicide), Rayner *et al.* [20] found that there was limited empathy and antipathy (negative attitudes), but this was not predominately negative or extreme in the five research studies included in the statistical analysis.

The findings of this study indicate the possible role of anticipatory stigma within the participants lived experience. 'Time must be brought to light and genuinely grasped as the horizon of every understanding and interpretation of being' [14], p.17. Some participants expected to encounter negative stigma within the hospital setting, being reluctant to attend due to the fear of being judged. Rayner & Warne [13] in their qualitative research reported that self-injury (including suicidal behaviour) could be conceptualised as a cycle of anger and shame, which was reported by participants as a method to initially avoid shame that also brought on a shame response from others when they presented for help in emergency departments. This in turn could trap the person into feeling a failure and worthless and exacerbate the need to self-injure. Rayner & Warne [13] reported that participants expected blame and stigma from other people, including health professionals.

The power and impact of human kindness from staff on participants was a pivotal finding, reflecting previous studies [5,6,7]. The importance and value of establishing a positive relationship with patients with suicidal intent or behaviour, being evidenced as improving outcome [23]. Concepts such as compassion, including kindness, have also been advocated for use with people who self-injure/harm, irrespective of wish to die or not [13,24,25]. If staff express compassion and kindness, it can challenge some of their core beliefs of "I'm not good enough" or "I don't deserve to be helped" [25]. This was supported with evidence from the participants in this study.

McCormack *et al.* [26] recognise that there is a gulf between the rhetoric of person-centredness and the realities of experiences for patients, families, and staff. There are many blocks to delivering person-centred care in the NHS today, including staff burnout and time pressures that have been exacerbated with the pandemic. Compassion fatigue and staff burnout affecting nursing care due to COVID-19 [27].

Interestingly however, the findings of this research suggest that time is not always a fundamental factor in offering a helpful encounter. For example, a busy nurse remembering her name as she went out for a cigarette, made one participant feel hopeful; another a paramedic wishing a participant 'good luck' 'meant everything'.

3.1. Implications for practice

When caring for patients following suicidal behaviour, staff need to recognise that individuals may be fearful of dying and seek to provide an opportunity for such fears to be heard and acknowledged. Patients who are unlikely to die, should be explicitly reassured. Emergency nurses can draw upon this research to help them understand that suicidality can be in one moment and gone the next. The patient may welcome death at one point and be scared of death at the same time.

Staff need to be aware that, following suicidal behaviour, patients may anticipate and experience high levels of shame and embarrassment. Accordingly, patients should be offered privacy, where possible and safe to do so. This includes waiting areas, as the person may have an increased fear of negative evaluation from others.

Staff should be supported, through reflective practice and supervision, to recognise their own feelings and beliefs around patients who attend hospital following suicidal behaviour.

Education should be offered to staff to embrace person-centred care, connection and compassion when caring for individuals following suicidal behaviour. Emergency nurses can connect with the patient by finding and talking about similar experiences of interests. By discussing their connections, the staff would be increasing protective factors against suicide and reducing hopelessness, thus reducing risk.

In order to instil hope, patients should be offered information about support services available beyond statutory services. This should include support and treatments options, care plans and safety plans, support groups, charities, and online forums.

3.2. Strengths and limitations

This study offers a contribution to knowledge in revealing aspects of the lived experience of being in emergency care following an overdose with suicidal intent. Uniquely, this study captures this data while the participants were still inpatients, receiving clinical treatment and within 48 hours of their suicidal behaviour. This study does, however, contain several limitations in terms of generalisation. First, phenomenological studies prioritise depth of experience from a limited number of participants, over the analysis of large data sets. Such findings however, can offer powerful insights that can cause us to question clinical practice and ideas. In terms of generalisability and predication of future behaviours, this study explores the individual nature of peoples in depth experiences. Therefore, the predictive role of psychometrics is limited as relies on generalisability and instead a full personalised risk assessment needs to continue to be provided by emergency triage and then the mental health practitioners.

Secondly, only six of the participants agreed to have their interview recorded, the other interviewees requesting that notes were taken. This limits the capturing of the fullness of the accounts offered. It was, however, an explicit ethical requirement of the HRA for note taking to be given as a clear alternative to audio recording. Thirdly, the interviews were relatively short in length, due to the clinical environment and the wellbeing of the participants. Short interviews can, however, produce rich data.

4. Conclusion

Staff working within EDs frequently perform an important role in caring for individuals impacted by suicidal behaviour. Research suggests however, that the experience of this patient group is frequently negative. This phenomenological study uniquely captures the lived experience of being in ED following an intentional overdose, while participants were still receiving emergency care as inpatients.

In order to improve the experience of this patient group, the findings of this study affirm the importance of emergency nursing staff offering compassionate person-centred care, demonstrating respect. Nursing staff should look for ways to connect, identify and empathise with the person ("be human" with them). Protect privacy where possible and avoid onlookers due to increased shame experiences. Finally, staff should recognise the transient nature of suicidality and possible fear of dying and also offer them some hope for the future.

CRediT authorship contribution statement

David Lee Anderson: Conceptualization, Methodology, Investigation, Writing – original draft, Writing – review & editing, Visualization, Project administration, Data curation. **Gillian Rayner:** Conceptualization, Visualization, Formal analysis, Methodology, Data curation, Supervision, Validation, Writing – review & editing. **Jean Duckworth:** Formal analysis, Methodology, Conceptualization, Supervision, Validation, Writing – review & editing.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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