



ORIGINAL ARTICLE

Impact of suicide on health professionals in psychiatric care mental healthcare professionals' perceptions of suicide during ongoing psychiatric care and its impacts on their continued care work

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ABSTRACT: People who attempt suicide as well as those who actually take their own life often have communicated their suicidal thoughts and feelings to healthcare professionals in some form. Suicidality is one of the most challenging caring situations and the impacts of suicide care affect both the professional and personal lives of healthcare professionals. This study investigates how mental health professionals perceive suicide while providing psychiatric care and how this perception impacts their continued care work. This qualitative exploratory study includes 19 mental health professionals in psychiatry who had provided care for patients who had taken their own life. Analysis followed the principle of phenomenography. The findings reveal that these healthcare professionals experienced an internal conflict that affected them both personally and professionally. In response to these conflicts, the healthcare professionals developed strategies that involved a safety zone and increased vigilance. Those who were able to commute and balance a safe spot and learning to be more vigilant seem to have developed as a result of patient's suicide. These findings have the potential to help establish a post-suicide caring process where healthcare professionals learn to make better suicide assessments, become more open to talking about death with patients, and develop a humbler approach to understanding a patient's suicide.

KEY WORDS: health personnel, phenomenography, suicide.

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INTRODUCTION

Healthcare professionals (HCPs) focus on healing, but inevitably they must deal with the death of a patient (Whitworth 1984). When death occurs, HCPs should have the opportunity to process and reflect on the affects the death may have on their professional and personal lives (Orbach 2008; Rehnsfeldt 1999). Both the healthcare system and the public view deaths during ongoing curative and preventive care (in contrast to palliative care) as avoidable and therefore the result of medical error. Therefore, assigning responsibility for these types of deaths requires assessing organizational factors and the decisions and professional actions

carried out by HCPs (Nirui & Chenoweth 1999; Pratt & Jachna 2015). In addition, questions of responsibility form part of an HCP's own inner reflective process (Carlen & Bengtsson 2007; Hagen, Knizek & Hjelmeland 2017). The contact, interaction and caring relationship formed with a person in a suicidal state (i.e. actively contemplating death) are a sharp contrast to the life-oriented focus of HCPs. The suicidal state challenges the profession's responsibility for life and death and can impact a HCP's own existential being (Draper *et al.* 2014; Pallikkathayil & Morgan 1988; Sjøberg *et al.* 2018). Therefore, it is important to understand how a patient's suicide impacts a HCP's continued care work related to suicide risk assessments.

BACKGROUND

International research has found substantial variance (20–90%) in the frequency of contacts between HCPs and people who eventually die by suicide (Appleby *et al.* 1999; Chung *et al.* 2017; Luoma, Martin & Pearson 2002). In Sweden, about 25% of people who die by suicide have been in contact with psychiatric care (Reutfors *et al.*, 2010). It seems that people who attempt suicide (Coombs *et al.* 1992; Wolk-Wasserman 1987) as well as those who actually die by suicide (Iso-metsa *et al.* 1995) in some way communicate suicidal thoughts and feelings to HCPs. Research has also highlighted that HCPs working in psychiatric fields are more aware of suicidal states (Davidsen 2011) than HCPs working in other healthcare fields, such as primary care (Cole-King & Lepping 2010).

Suicidality is described as one of the most challenging caring situations an HCP can face (Hagen, Knizek & Hjelmeland 2017). Suicide can impact HCPs, irrespective of specialization, greater than other sudden deaths (Draper *et al.* 2014; Grad, Zavasnik & Groleger 1997). A patient's suicide can result in HCPs regulating their psychological patterns and experience, which ultimately alters the way they engage with patients (Hagen, Knizek & Hjelmeland 2017; Wang *et al.* 2016). An adverse incident can result in HCPs experiencing shock, devastation, sadness, guilt, shame and grief, psychological devastation that has even resulted in death by suicide of HCPs (Hendin *et al.* 2000; Pratt & Jachna 2015; Ruskin *et al.* 2004). The difficult position in which HCPs find themselves after experiencing a patient's suicide has been described as becoming 'the second victim' (Pratt & Jachna 2015). Joyce and Wallbridge (2003) found that some HCPs blame one another, blame themselves and fear being held

responsible for the death of a patient even though the care they had given before the patient's suicide had maintained the expected professional and organizational standards. Hultsjö, Wärdig, and Rytterström (2019) describe how HCPs reflect on the influence of organizational changes on a suicidal patient's fragile state. The impacts of suicide care affect both the professional and personal lives of HCPs (Draper *et al.* 2014; Graham, Rudd & Bryan 2011; Joyce & Wallbridge 2003). Whitworth (1984) describes this impact in terms of an interpersonal conflict between the life-oriented core of the work of mental health nurses and keeping someone alive who does not want to live. Hultsjö, Wärdig, and Rytterström (2019) also found that HCPs experienced an emptiness caused by their inability to relieve a patient of suicidal thoughts, and this experience stayed with the HCPs beyond the death of the patient, a response often triggered by other suicidal patients.

Clearly, knowledge how suicide of a patient impacts HCPs can be used to develop better routines for the care of HCPs who have been impacted by the suicide of a patient. These routines include debriefing, providing employee assistance programmes, using case session scenarios, examining medical records and providing opportunities for HCPs to learn more about suicide prevention (Pilkinton & Etkin 2003; Takahashi *et al.*, 2011). In addition, HCPs who experience a patient's suicide while under psychiatric care can be helped through the reframing of how the event is experienced (Joyce & Wallbridge 2003). This reframing could include providing HCPs opportunities to reflect on their views of life as valuable and important and by encouraging them to reflect on their vigilance and commitment to their job.

Negative reactions from HCPs towards suicidal patients may be related to the stigma attached to death by suicide (Fremouw, Ellis, & Perczel, 1990). Talseth, Norberg, and Beskow (2001) further showed how these negative feelings could result in projection, denial and repression, emotional states that could cloud their ability to detect suicide risk in patients. HCPs can psychosomatically mirror the suffering of suicidal patients, which is often manifested as what HCPs refer to as wearing a mask to hide their real feelings. There is a need to explore how HCPs handle and communicate this unbearable suffering, and how risk, as a predominant characteristic of and tool in suicide care, inhibits the authenticity of HCPs (Hultsjö, Wärdig & Rytterström 2019). In other words, there is a need to understand how the unavoidable and deep impact of a

patient's suicide impacts how HCPs understand themselves and their profession. Therefore, this study aims to understand mental health professionals' perceptions of suicide during ongoing psychiatric care and its impacts on their continued care work.

METHODS

Design

As there is little research in this field, an inductive exploratory study that uses a phenomenographic approach was considered appropriate (Sjostrom & Dahlgren 2002). Phenomenography generates different content-related descriptive categories of participants' experiences. The categories represent what (1st order perspective) and how (2nd order perspective) the phenomenon is experienced and described and are based on experiences in reality.

Data collection

This study used a purposeful sample (Patton 2015) of 19 HCPs who had at least 2 years of professional experience in psychiatric care and who had experience working with patients who had died by suicide within the last 3 years of their care. Participants were recruited from three different regions and came from a variety of backgrounds (Table 1). These HCPs were working within psychiatric care and were in daily contact with patients. We included HCPs from different regions to minimize the risk of capturing localized care cultures in healthcare staff, a design strategy Patton (2015) refers to as representativeness. In addition, including four regions provided a richness in perceptions of the patient's suicide and the suicide's impact on their continued care work. When approval had been received from healthcare managers, unit managers were contacted with information about the study and were asked to identify individuals who satisfied the inclusion criteria. These potential participants received information about the study. If they were willing to participate, they forwarded their name and contact details to someone in the research group. Contact was established with those interested in participating to plan the time and place of the interview.

The interviews were conducted between 2016 and 2018. The participants chose the location for the interviews, which were held in different clinics. Before the interview started, HCPs received information about the study and left their written informed consent. To

TABLE 1 Characteristics of the study population from three regions in Sweden

Participants/professions	Total 19 (region 1: 7 participants, region 2: 7 participants and region 3: 5 participants)
Years of experience	2–32 (†14)
Psychiatric nurse	10
Assistant nurse	7
Psychologist	1
Physician	1
Gender	
Female	9
Male	10
Place of work	
Forensic psychiatry	4
Psychiatric outpatient care	7
Psychiatric inpatient care	8

†Values are median (range).

create a safe and relaxed atmosphere, the interviewers engaged the participants in general conversation and gave them the opportunity to ask questions. The interviews followed a semi-structured guide with an open question: Can you share your perceptions of caring for a patient who died by suicide during the period of care? For clarification purposes or to encourage more in-depth answers, probing questions (Dahlberg, Dahlberg & Nyström 2008) were asked – for example 'Can you tell me more?' and 'Can you describe a situation and its impact on your ongoing care work?'. After the interview, HCPs and interviewers were given time to reflect on their interview experience, a technique based on the idea that nobody should have to leave the room before they felt ready. The interviews were recorded as digital audio files and transcribed verbatim using a transcription guide (McLellan, MaCQueen, & Neidig 2003). The interviews were conducted by all authors. During the whole interview process, the authors shared their interview transcriptions and they frequently met to compare interviews and establish coherent content for all interviews.

Analysis

The analyses followed the principle of phenomenography (Sjostrom & Dahlgren 2002). The transcripts were read through by all authors several times to obtain a sense of the whole. In the next step, the following questions were asked about the text: What are the

different ways of perceiving? and How is it perceived? Significant statements were identified and marked with a highlighter, and longer statements were shortened to illustrate the most central part of the statement. Similar statements were grouped together into primary descriptive categories. The primary descriptive categories were compared to divide variations and to establish categories that were distinct from each other. The descriptive categories were compared, contrasted and labelled to capture the essence of the understanding. In phenomenography, categories can be viewed as a framework that describes the qualitative differences associated with experiencing a phenomenon. Since the categories provided different aspects of the total picture, logical relationships between the categories were also identified. The categories and their relationships were defined as the 'outcome space', which is seen as the main outcome in phenomenography (Sjostrom & Dahlgren 2002). The categories in this study were related to one another in a hierarchical and horizontal way.

Ethical considerations

The principles of written informed consent were followed, and the study was approved by the Regional Ethical Committee (Dnr: 2016/343-31). The study was designed and implemented in accordance with the World Medical Association Declaration of Helsinki and ethical principles for medical research involving human subjects (2013). To help contextualize respondents' experiences, the interviews were conducted by nurses specialized in psychiatric care.

RESULTS

The 'outcome space' consists of three descriptive categories (Fig. 1) that illustrate what HCPs perceive after a patient's suicide: 'Experiencing internal conflict', 'Creating a safe spot' and 'Becoming more vigilant'. The 'Experiencing internal conflict' phase occurs before the phases 'Becoming more vigilant' and 'Creating a safe spot'. The variations within the descriptive categories involve descriptions of how HCPs manage the three phases. HCPs who were able to balance a safe spot and to be more vigilant seem to have developed personally and professionally from the experience, whereas HCPs who tended just to create a safe spot mainly described how they felt uncomfortable and focused on avoiding similar situations.

Experiencing internal conflict

Healthcare professionals described how they experienced internal conflicts that affected them on a personal and professional level. Regardless of whether they had previous experience of caring for a patient who died by suicide, it was clear that all HCPs were subject to this phase. How they perceived the suicide was affected by the meaning and understanding they attributed to the situation as well as their experiences of access to support.

Searching for meaning and understanding

After a patient died by suicide, HCPs initially experienced emotional stress on a personal as well as on a professional level. At first, they described how they experienced chaos, a vacuum characterized by guilt and stress:

I broke down, [. . .] I felt very guilty. I was the one who let the patient out (2)

In addition, they struggled to search for meaning and understanding in terms of what had happened. Many expressed sadness, felt they had not done enough and grasped for answers in order to understand the incident:

You investigate yourself [. . .] Everything was going well for him [. . .] and then he chooses to quit [. . .] Somehow it is a relief for him, but why? (1)

Healthcare professionals described experiencing emotional confusion, panic attacks and nightmares. HCPs who had been subjected to several suicides close together described how they had begun to question their own professional role and capacity.

These two suicides happened relatively close to each other in time. I had a dip in my role as a nurse. I wondered very much if it was me who had driven them to suicide. Seriously, [. . .] how could it happen to two of my patients? (8)

In addition, some HCPs worried that their colleagues would think they had done something wrong:

The worst assessment [suicide of a patient] of your job you can have from patients (7)

Although most HCPs felt they could move on after the event, the experience consistently raised many questions and emotions that they carried with them for a long time.

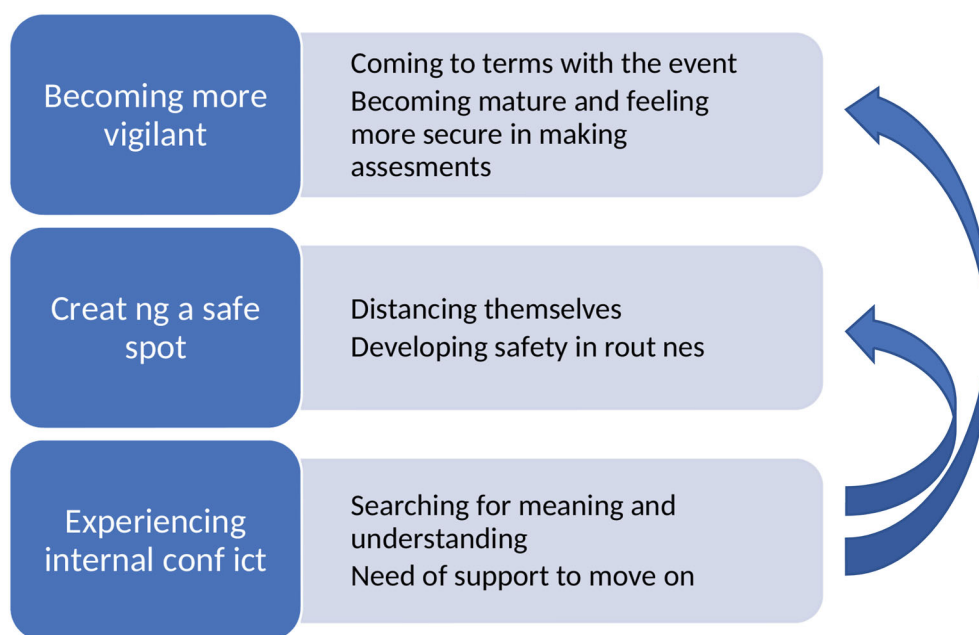


FIG. 1 The outcome space illustrates healthcare professional's perceptions of suicide during ongoing psychiatric care and its impacts on their continued care work.

Need of support to move on

The statements revealed that HCPs needed support in order to cope with the event. The specific support required by an HCP varied, ranging from a pat on the shoulder to crisis calls or someone asking about how they felt. They valued being informed orally when a patient took his or her own life and appreciated offers to talk about the event:

You had to have this pat on the shoulder a little more [. . .] that someone asks how it feels. If it feels hard. You want to [. . .] I mean only the usual. [. . .] Is everything all right? Can we do anything to help you?

(7)

However, it emerged that the HCPs did not actively seek support themselves but were asked if they wanted support. Talking and processing the event was described as a way of gaining understanding and closure. It also became important to hear from relatives of the deceased that the HCP had not made mistakes:

The parents had found on her computer that she had done a search to find out how to kill herself in a care department. They firmly believed that she wanted to die here in the care department, where she would be found soon, and not in her parents' home. So in contrast to my own frustration, they were calm about the fact that she was here. That also calmed me down. (4)

Creating a safe spot

Some HCPs chose to avoid the event by developing procedures for protecting themselves in a similar event. This did not mean that creating a safe spot was always negative or that the event had not been processed. Some of the HCPs described how they learned and matured after the incident and how they had created safe spots to maintain a good attitude or to cope with strong feelings and reactions in a professional way.

Distancing themselves

Some HCPs had not come to terms with the incident, but had distanced themselves from the experience. Some described how they felt so bad that they had changed their job or avoided situations such as the one preceding the suicide:

I find it difficult to go to patients, especially in the evenings and early mornings, because I don't want to step into a hanging [. . .] you are subconsciously looking for signals [. . .] is someone depressed? [. . .] You indicate to the rest of the staff that you don't want to go into this room because you have an unpleasant feeling. (9)

Others described how they had distanced themselves from certain suicidal patients because it affected them so much that they could not cope:

They [suicidal patients] eat me up. You can't motivate and you can't comfort. [. . .] It consumes me in such a way that I turn off in the end (19)

Some HCPs developed their own mental health issues. Others described how colleagues had to change jobs due to mental illness:

I see colleagues who [. . .] develop some PTSD-like symptoms. Really sad [. . .]. It's very painful (4).

Developing safety in routines

Suicide had consequences for daily care work. HCPs described how routines on the unit became more precise. The routines could consist of monitoring lists, follow-up calls, or becoming more observant during extra monitoring. HCPs whose movements were entered into logs after a suicide tended to start documenting their routines to cover themselves:

It was an unpleasant thing [. . .] being examined. [. . .] I showed that I had not done an MADRS-S. [. . .] I had written my assessment in running text. [. . .] I should have referred to some suicide risk instrument. Now I just write "not suicidal according to the suicide ladders" on every visit if I have a patient who is at risk of suicide, just to cover myself. [. . .] I write that very often nowadays [. . .] and my colleagues do too. (7)

In some workplaces, it was found that the whole care process had been organized to create a safe spot for staff. Several people were involved in assessments, which gave HCPs backup and developed protection and security. This strategy helped HCPs to distance themselves and to cope with working with daily suicide risk assessments. However, some of the HCPs commented that estimates could become meaningless if they were used routinely just to strengthen the documentation or to cover the staff and that they should complement communication with the patient:

The suicide ladder we are hooked up to [. . .] health-care is examined, and this suicide ladder is crucial. But the phases of suicide cannot be treated in a sloppy way. They must be part of a conversation in a meeting with patients to check they're more or less okay. And it's not always easy. (18)

Becoming more vigilant

This descriptive category involved HCPs coming to terms with the incident. They described how the suicide had made them develop and mature. Feeling safe and secure was described as balancing different

perspectives against one another and learning from mistakes.

Coming to terms with the event

Although the suicide was initially a painful shock, it became evident that most HCPs eventually came to terms with the event. In this phase, the suicide was described as 'complex', and something they related to with a degree of humility. One aspect that emerged was how HCPs seemed to generate an understanding of a patient's life situation:

[. . .] when they realise that it's a lifelong disease and that it involves a form of disability, and that society views people with this disease in a certain way. Then you might choose to end your life [. . .]. I can understand that. (16)

The descriptions given by HCPs of how they developed a different understanding of the event included the idea that instead of ignoring what had happened and looking for scapegoats they should look at it more objectively. Although the event deeply affected them, HCPs highlighted the importance of learning from the event and moving on:

Being able to handle negative events [e.g., suicide] and learn something from them. Work around it. There and there I should have done this or that. You mustn't let it get you down. (4)

Becoming mature and feeling more secure in making assessments

Although suicide was always associated with feelings and thoughts, some HCPs seemed to be more prepared and knew it could happen. Becoming mature and feeling more secure in making assessments involved being strong enough to give the patient more responsibility and raise questions about death:

It has made me more comfortable about asking and talking about suicide. What do you think about death? Do you want to die? Asking those questions. [. . .] I have a strong feeling about whether the answers are genuine. (11)

The statements illustrate that HCPs could become more mature after a patient takes his or her own life. They illustrate how they become more observant of small signs in the patient's expressions. They also dare to trust their intuition and follow orders more carefully. Although previous suicides could still be perceived as emotionally draining, HCPs described how they had developed and how they had learned a lesson that

could permeate their care work and their communication with patients:

I have tentacles in all directions. [. . .] When you have been working a long time, it is enough to step into the department to feel [. . .] to read it [. . .]. I'm more responsive. [. . .] I can't really explain what it is that comes to me when I'm close to patients who are suicidal [. . .] they radiate something. (6)

Becoming more mature and more confident about their own judgement is not always about making the right decision to ensure the patient survives. It can also be about making a decision even when there is a risk that patients die by suicide:

A well-educated man [. . .] had ended up in a refugee camp. [. . .] He thought the Migration Board had treated him like dirt and he was extremely frustrated with the situation [. . .] he was hospitalised and I would meet him. [. . .] He did not have a mental illness. Incredibly frustrated and offended and didn't want to be trapped. [. . .] He said, "I can't stand this and I can't see another way out". However, being locked up in a psychiatric ward didn't solve anything for him [. . .] and pretty soon after our meeting he took an overdose of medication and died [. . .] (3)

Although the patient had no indications to warrant admittance to psychiatric care, the HCPs found the patient's life situation so hopeless that the suicide came as no surprise.

The HCPs relationship with their patients matured as they developed a sense of security, and this security was also apparent in their relationship with relatives of patients who died by suicide. HCPs described how important it was to be honest and maintain a degree of humility, to be honest and to show that it is not a prestige issue.

DISCUSSION

The results show that HCPs in psychiatric care are affected by a patient's suicide and that this impact has consequences for how they care for suicidal patients. Three descriptive categories were identified: 'Creating a safe spot', 'Becoming more vigilant' and 'Experiencing internal conflict'. Impacts of a patient's suicide on HCP practice could be viewed as variations lying somewhere between developing a safe spot and becoming more vigilant. In these situations, HCPs can experience both stress and maturity as well as both guilt and understanding in terms of why the patient died by suicide. These findings confirm previous results that found

that HCPs experience negative impacts as a consequence of suicide in psychiatric care, such as guilt, stress and avoidance (Pratt & Jachna 2015). In addition to each HCP's very subjective experience, they shared similarities with other HCPs in the care context, such as guilt and blame (Goldstein & Buongiorno 1984; Hendin *et al.* 2000).

The consequences of patient suicide for HCPs are both personal and professional (Tillman 2006), and this is manifested in the descriptive category of internal conflict in this study. Research discussing the process in HCPs after a patient's suicide describes feelings and expressions of guilt, blame and anger, followed by a phase where they develop understanding and acceptance (Horn 1994). Interestingly, Tillman (2006) describes another aspect of blame, where colleagues try to reassure an HCP not to feel guilty too soon after the event. A sense of shared experience of guilt and blame might be important. The initiative taken and courage shown by empathizing with an HCP could be important in combatting isolation. This could help an HCP avoid becoming stuck in phases of the process or abandoning the process before reaching the stage of what this study describes as becoming more vigilant.

However, this study shows how HCPs can come to terms with and learn from a patient's suicide, an area of study not well described in previous research. These results suggest that HCPs make better suicide assessments as a result of the experience and feel more able to ask patients questions about death. The experience, if properly processed, also makes them more alert and aware of new signs of suicide. This maturing process may result from understanding why a patient has died by suicide. HCPs have followed the patient's life struggle and can express, among other reactions, relief that the patient is no longer in pain. Davidsen (2011) describes how it could be easier to cope with patients who had expressed ideas about suicide than with patients who had died by suicide unexpectedly. A caring approach that tries to understand the suicide patient's suffering (Berglund, Åström & Lindgren 2016) may be beneficial for patients (Sellin 2017) as well as enable HCPs to provide suicide prevention care, and this may act as protection for them if a patient dies by suicide.

To cope with a patient's death by suicide, HCPs developed a safe spot and established routines as a foundation for care work related to patients at risk of suicide. It is important for anyone caring for patients with suicide ideation to develop routines for identifying the extent to which they are contemplating or planning

suicide. In care work, however, routines are described as both obstructive and meaningful (Rytterstrom, Unosson, & Arman, 2011). Routines can become obstructive when they are not adapted to a patient's individual situation, and they risk aiming at the safety of caregivers more than the patient. This approach is passive care that focuses on one side of risk factors and safe observations, rather than active care that sees the patient as capable of managing both challenges and opportunities in life and incorporating meaning into life. This study highlights the important observation that care, which is governed mainly by and organized around safe spots, is more about exonerating the clinic and staff than addressing the very sensitive conditions and diverse situations in which a suicidal person is immersed. We argue that care centred on safe spots and risk assessment instruments can become counterproductive when it begins to treat the risk itself rather than the condition or when it fails to consider the life situation of the suicidal person as a whole. The one-sided focus of risk assessment may also cloud the subtle and implicit signs a suicidal patient is trying to communicate.

Understanding a patient's life struggle and suffering is also in keeping with HCPs' need for support after a patient has died by suicide. The delicate nature of constructive support is seen in descriptions of small but concrete forms of support in terms of emotional, verbal and physical gestures. This finding suggests that the support from colleagues and a place for real understanding and communion are constructive. The vulnerability experienced by HCPs after several patient suicides in a short period highlights the need for individualized support for each HCP's specific circumstances, such as their experience, their personality and their time. It also highlights the role of shared experience in patient suicide.

Limitations

It is important to bear in mind that this study reflects a Swedish healthcare context involving Swedish legislation and governance, and readers should decide whether the results are applicable to their contexts. It could be seen as a limitation that the research involved four different interviewers as their interview techniques are likely to have been different even though each interview was based on the same research question. In these interviews, the aim was to create an atmosphere of trust, so the interview guide served more as a support. However, to minimize any associated risks, the authors discussed all interviews carefully to understand

the data and become familiar with the interviews conducted by the other authors. The analysis was flexible, moving back and forth, and several meetings of the research group at monthly intervals ensured quality and enabled a reflective approach.

A strength of the study, which is consistent with phenomenography, is that it captures extensive variation in the participants' profiles in terms of age, gender, number of years in the profession, different occupational groups and a variety of psychiatric workplaces. In this way, it is likely that 20 participants with differing backgrounds cover a wide variety of experiences, as there are a limited number of ways to experience a phenomenon within a group of people (Marton *et al.* 2000). In addition, quotations from the interviews support credibility, and the reader can judge whether the categories are relevant (Sjostrom & Dahlgren 2002).

Relevance for clinical practice

After a suicide, it is important not to rely on a simple one-sided focus as described in the category 'Creating a safe spot', which involves passive care measures like extra monitoring and risk assessment instruments. More active care measures should also be applied, as described in the category 'Becoming more vigilant', where HCPs experience and acquire knowledge about suicide and learn how to grasp why it has happened. Crisis management with a focus on meaning and understanding could help HCPs prevent future suicides. HCPs can become more mature if feelings of shame and guilt after a patient's suicide are not seen as something to overcome but as a starting point to learn from and become more vigilant. Therefore, it seems relevant to formalize support from colleagues as they have an important role in this post-suicide caring process.

CONCLUSION

Experiencing a patient's suicide affects HCPs deeply and raises the question of how a patient's suicide can be understood. Elaborating on these questions is important as in the long term it can support HCPs in terms of learning how to make better suicide assessments, becoming more open to talking about death with patients, and developing a degree of humility in understanding a patient's life situation. This post-suicide caring process is a significant addition to processes where the focus is on developing safe spots such as revising routines for assessing the degree of suicide risk.

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