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Family care of Taiwanese patients who had attempted suicide: a grounded theory study

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Abstract

Title. Family care of Taiwanese patients who had attempted suicide: a grounded theory study.

Aim. This paper is a report of a study to explore family carers' and suicidal ex-patients' perceptions of the home environment and the provision of care in the home.

Background. Worldwide, in 2000 approximately one million people died from suicide, which is among the three leading causes of death among those aged 15–44 years. Internationally, epidemiological trends show that there has been a rapid increase in suicide rates in many countries, including Taiwan. Families have an important role in caring for a member who is at risk of suicide.

Methods. Using a grounded theory approach, data were collected in 2006–2007 in two Taiwanese hospitals. Interviews were conducted with suicidal patients who had just been discharged (n = 15) and family members (n = 15). Data were analysed using open, axial and selective coding.

Findings. For the purpose of a larger study a substantive theory was formulated, which families could use to guide them in the care of a member who is at risk of suicide. Here we report the findings related to the 'context' and 'intervening conditions' of the grounded theory. Two categories emerged in the 'context' element, namely 'the family environment' and 'the Chinese culture'. One category surfaced in the 'intervening condition' namely, 'The provision of care in the home'. This category included three sub-categories: support systems; coping mechanisms and helping skills.

Conclusion. Family carers experienced difficulties when caring for a member who had previously attempted suicide. Before patients are discharged from hospital, nurses should educate families on the preventive and caring approaches that they could use in their homes.

Keywords: coping, discharge, family caregivers, grounded theory, mental health, nursing, suicide

Introduction

In 2000 approximately one million people died from suicide: a 'global' mortality rate of 16 per 100,000, or one death every 40 seconds. Suicide is among the three leading causes of death among those aged 15–44 years (World Health Organization 2007). Internationally, epidemiological trends show that there has been a rapid increase in suicide rates in many countries, including America (10·4/100,000 in 2000; 11·0/100,000 in 2004); Japan (24·1/100,000 in 2000; 27·0/100,000 in 2005) and Taiwan (11·14/100, 00 in 2000; 19·3/100,000 in 2006) (World Health Organization 2007). In Taiwan, suicide was the ninth leading cause of death overall and the second principal cause of death for 15- to 24-year olds in 2006 (Department of Health, Executive Yuan, Taiwan, ROC 2007).

Background

The suicide rate in Taiwan doubled in the last 10 years and 4406 people lost their lives by suicide in 2006 (Department of Health, Executive Yuan, Taiwan, ROC 2007). The most frequently used methods were hanging, poisoning and jumping from high places (Department of Health, Executive Yuan, Taiwan, ROC 2007). In response, the Department of Health in Taiwan supported the setting up of the Taiwan Suicide Prevention Center (Lee *et al.* 2006). This centre has established networks nationwide and delivers related care services. The core values underpinning the centre's mission statement are related to 'Cherishing life and restoring hope' and also 'Suicide prevention is everybody's business' (Suicide Prevention Center of Department of Health 2007).

Because of Chinese cultural expectations and obligations, families in Taiwan play a significant role in providing care for their members with a mental illness, including repeated suicide attempters (Tung & Gillett 2005). Therefore, families experience enormous stress, not only physically but also emotionally, financially and culturally, because they are obliged to care for their relatives who attempt suicide. Further, suicide is stigmatized in Taiwan and families experience intense shame following suicide or a suicide attempt. This shame places enormous pressure on both the survivor's ability to interact with society and the family's relationship dynamic in the community, and often results in families feeling isolated and marginalized during the period immediately following the suicide event (Tzeng & Lipson 2004, Cvinar 2005).

Qin and Nordentoft (2007) used a nested case–control design to explore suicide risk in relation to psychiatric hospitalization in Denmark and found there were two sharp peaks of risk for suicide: one in the first week after admission and another in the first week after discharge. Deisenhammer *et al.* (2007) studied a sample of patients who had been discharged from hospital (n = 665) in Austria and found that 28·4% took their own lives within 7 days of discharge. This evidence suggests that a systematic suicide risk evaluation should be carried out with psychiatric patients before they are discharged and during follow-up outpatient appointments. In addition, Tzeng (2001) has concluded that healthcare professionals should continue to provide interventions after suicidal patients return to the community. However, most of the research into suicide has focused on the nursing care of suicidal people (Cutcliffe *et al.* 2006, Sun *et al.* 2006a), and little is known about suicidal patients' home life after discharge.

The study

Aim

The aim of this study was to explore family carers' and suicidal ex-patients' perceptions of the home environment and the provision of care in the home.

Design

The data reported in this paper are part of a larger study the aim of which was to develop a theory that families could use as a map to guide the provision of care for suicidal ex-patients. A grounded theory (GT) approach was considered to be the most appropriate approach to use as the research concerned an experience (suicide) and the phenomenon in question was a process (home care) and the goal was the development of a theory (Denzin & Lincoln 2000).

Participants

A purposive sampling technique was used initially, and then theoretical sampling guided the selection of further participants (Williams 1998). Theoretical sampling is based on the emergence and saturation of concepts, subcategories and categories, which are then used to develop a substantive theory. For example, when the category of 'The family environment' began to emerge from the data, an additional two family carers were selected to elicit more data about variations along this dimension in order to reach saturation of this category.

Former patients (n = 15) were recruited who had had suicidal ideations for two weeks prior to data collection or had previously attempted suicide. Family participants were members of the family who would be caring for their relatives

after they had been discharged from hospital for at least 3 days. The patients included both women (n = 12) and men (n = 3); they were aged 21–69 years; single (n = 5), married (n = 5), divorced (n = 5), religious (n = 8) and non-religious (n = 7); and had been diagnosed with depression (n = 14) or schizophrenia (n = 1). Of these, 13 had been admitted following attempted suicide and 12 had made more than one attempt. The remaining two had experienced suicidal ideations for over 2 weeks.

The family carers (n = 15) were also recruited and also included both women (n = 6) and men (n = 9); aged 21–70 years; they were single (n = 3), married (n = 10), divorced (n = 2), religious (n = 12) and non-religious (n = 2). Their relationships with the patients were: partners (n = 6), parents (n = 4), siblings (n = 3), children (over the age of 20) (n = 2). The period of family care ranged from 3 to 42 days following discharge.

Data collection

The study was conducted in two hospitals in Taiwan in 2006–2007. Each participant was interviewed once for about 60 minutes after patients had been discharged from hospitals for at least 1 week. Arrangements were made to conduct some interviews (n = 18) in quiet rooms in the two hospitals when patients returned to the outpatient departments and some (n = 12) were conducted in the family's home. The initial interview guide for both family carers and ex-patients examined the following themes: (1) Thoughts and feelings on home care; (2) Communication strategies used in the home; (3) Difficulties experienced; (4) Coping with the difficulties; (5) Use of outside resources; (5) Relationship dynamics and (6) Reasons why people attempt suicide. In keeping with one of the key tenets of GT, namely theoretical sampling, the interview guides were continuously adapted by adding questions related to the concepts that had surfaced in previous interviews until theoretical saturation of the emerging categories occurred.

Ethical considerations

The study was approved by a university ethics committee and the two hospitals' institutional review boards. Participants were informed of the purpose of the research and consent forms were signed. Several steps were taken to protect participants from harm:

- Rigorous criteria for selection and exclusion included a psychiatrist assessing patients to determine their fitness to participate, as well as their ability to understand the meaning of informed consent.
- The consent process was ongoing and participants were informed of their right to withdraw from the process at any time without prejudice.
- Interviews were conducted when participants felt able and willing to share their feelings and thoughts on the topic.
- Counselling support was available for all participants after each interview.
- Confidentiality was maintained by using codes to identify participants.

After concluding the interviews, no noticeable effects on the participants were recorded.

Rigour

Four steps were used to improve the credibility of the study and ensure that participants' perceptions were identified and accurately reported. They were: (1) prolonged involvement, which meant that the lead researcher (F.K.S) met with the patients following their admission to hospital to enhance interpersonal trust; (2) use of data and investigator triangulation, which meant that data were collected at two hospitals and by two interviewers; (3) member checks, which meant that two family carers and two patients were involved in reviewing the findings to ensure that they were accurate representations of their experience and (4) expert review, which meant that three PhD-qualified nurse teachers experienced in GT research checked one transcription and all the narrative exemplars to see if the concepts, subcategories and categories that emerged matched those of the key researchers. These steps increased the credibility of the study. For the purpose of enhancing dependability, an audit trail was charted giving details and copious narrative exemplars.

Data analysis

In GT, data collection, coding and analysis are simultaneous processes from the beginning of a study to its conclusion (Strauss & Corbin 1990). In this study, the constant comparative method was used to analyse the contents of the typed transcripts. The constant comparative method facilitated discovery of the properties and dimensions of categories. Further, data were analysed using a combination of Strauss and Corbin's (1998) analytical framework comprising open, axial and selective coding, together with Eaves' (2001) 12 analytical steps to increase understanding and enhance the clarity of the analysis. The Eaves (2001) framework was derived from Strauss and Corbin (1990), Charmaz (1983) and Chesler (1987). QSR NUD*IST, N7 software was used to aid the coding, sorting and retrieval of

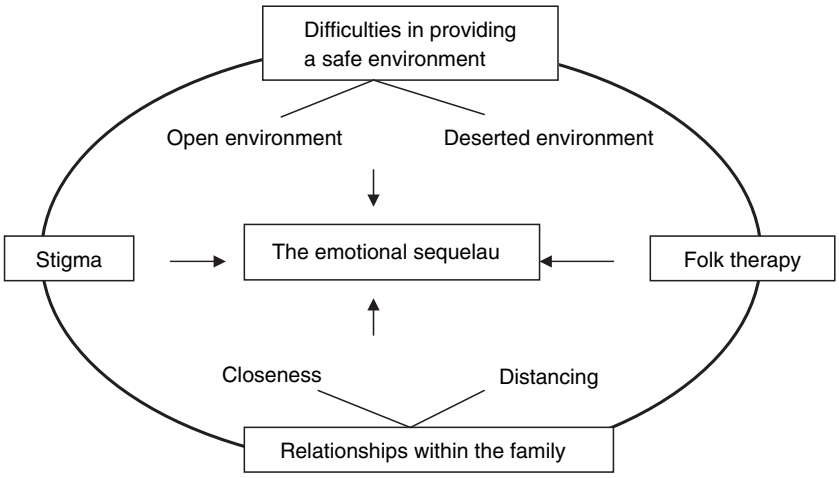

Figure 1 Context: family environment.

data. The main data analysis was carried out in the following manner:

- Open coding: After the collection of each participant's data, the taped interviews were transcribed. Then, the first seven steps of the Eaves (2001) framework were used. They were: (1) Line-by line *in vivo* coding, (2) Shorter code phrases were then developed to capture the main idea of what informants said, (3) Reduced phrases were composed by grouping together phrases with the same coding, (4) These were grouped together to create clusters. Clusters were then reduced into meta-clusters with labels, (5) Labels denoted the emergent concepts, (6) Similar concepts were grouped together to develop categories, (7) Subcategories were identified. Resulting from these steps, five subcategories emerged from the data relating to the context of the paradigm model (see Figure 1). Moreover, three subcategories emerged from the data relating to the intervening condition of the paradigm model (see Figure 2).

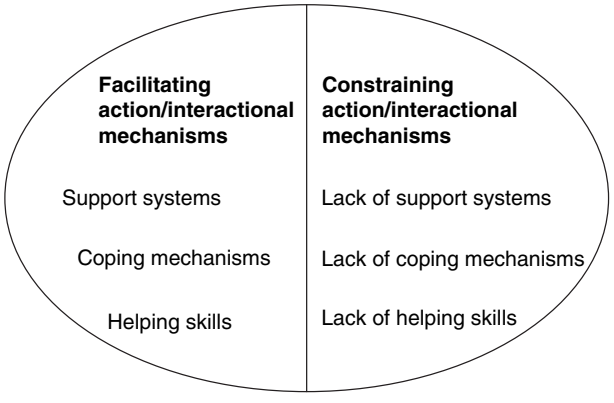

Figure 2 Intervening conditions: positive and negative effects of family care.

- Axial coding: This was used to link each category within the paradigm model.
- Selective coding: After sorting memos and diagrams, a substantive theory was generated from the data to guide families in the care of their relatives who are at risk of suicide.

Findings

A theory to guide families and carers of people at risk of suicide

For the purpose of the larger study, 11 categories were generated from the data and relationships between the categories were identified using the paradigm model recommended by Strauss and Corbin (1998). The basic components of the paradigm model are (1) Causal conditions; (2) Context; (3) Intervening conditions; (4) Action/ interaction strategies and (5) consequences. Each of the sections within the paradigm model interacts with each other. Finally, a substantive theory entitled 'A theory to guide families and carers of people who are at risk of suicide' was developed by linking the basic components of the paradigm model together.

In this paper we show how 'context' and 'intervening conditions' interacted with each other to define family carers' action/interactions when caring for suicidal patients at home.

The context

The context in this GT study relates to the home environment to which patients were discharged following a suicide attempt. Two categories were generated from the data relating to the context: family environment and Chinese culture.

Family environment

The first category, family environment, was subsequently reduced to three sub-categories, each of which was supported by a number of concepts, as described below and shown in Figure 1.

Difficulties in providing a safe environment. Participants perceived that the family setting was a hazardous situation because it was open, which meant that former patients had the freedom to leave at any time. Consequently, all family participants feared that the patients' might attempt suicide when outside the home. In addition, some family carers needed to go out to work, and consequently there were times when their relatives would be at home on their own with no one to care for them. This created further fear:

FM13: I really don't know how to prevent her from committing suicide because I take all the knives away in my home but she buys knives by herself.

FM6: I hope my wife will go to my mother's home, where they can care for each other. But I know she doesn't like that. So, I've to leave her alone at home when I'm working. I'm so worried because I can't control when she might attempt suicide.

Relationships within the family. The 'relationships within the family' sub-category was subsequently reduced to two concepts, namely closeness and distancing. Both of these concepts emerged equally. When there were close relationships in the family, more time was spent with the ex-patients, communicating with them and caring for them. Conversely, when relationships were perceived as 'poor', less time was spent with them and therefore communication was stilted. Being on their own meant that the former patients had more time to dwell on their negative thoughts and contemplate suicide:

P13: My husband's very nice to me. I feel that someone else would have abandoned me. Others give up on people like me. My husband says he'll not divorce me because I stood by him when he was going through a difficult time.

FM6: We'd financial problems. I was angry when I saw my wife spending money but I couldn't reprimand her in case she attempted suicide. So, I don't want to talk to her.

Emotional sequelae. Six different painful emotions emerged: dog-tiredness, anger, stress, fear, anguish and numbness. Many family carers felt tired of watching their relatives repeated behaviours or listening to their repetitive phrases. A few were tired of the repeated suicide attempts. Anger surfaced as the twin emotion of tiredness. Many said that they felt both fear and stress because they were afraid the ex-patients might attempt suicide again. In addition, a few felt anguished and numb about their relatives' suicidal behaviours because they had endured this experience 'too many times in the past':

FM 9: I'm tired of caring for her every time she attempts suicide. She sleeps all day and I stew ginseng and fish with medlar [a tonic] for her and carry it up four flights of stairs but all she does is sleep. I tell her I'm old and not fit for all this, but I still take care of her. All she wants to do is attempt suicide. I don't know what to do.

F3: I'm so stressed caring for my daughter because I'm always thinking: 'Is she safe today? Does she want to die? If she has any problems, I worry about her all day long.

Chinese culture

The second category, Chinese culture, was reduced to two sub-categories (see Figure 1).

Stigma. Family carers felt a collective shame about one of their members attempting suicide, mainly because Chinese culture deems suicide as a stigma. The sub-category 'stigma' was reduced to three concepts: shame, foolishness, and bu-hsiao [meaning that children who attempt suicide are not devoted to their parents]. Three narratives illustrate these findings:

F3: A neighbour's very nice and she often chats with me. But I could never talk with her about my daughter's suicide attempt because I feel so ashamed until now.

P13: My mother-in-law asked why I was so foolish to attempt suicide. She thought how I felt did not justify committing suicide. I didn't want to explain to her. I think she can't understand my suffering.

F3: I tell her that she's very cruel and bold. I remind her that her parents and grandparents gave her life and all she could do was attempt suicide. Her behaviour is so 'bu-hsiao'. Then, she falls on her knees and says sorry to me.

Folk therapy. Some participants turned to folk therapy to find help in reducing their relatives' thoughts of re-attempting suicide. This sub-category was subsequently reduced to two concepts: help from psychics and help from fortune-tellers:

P13: I find it very distracting that my mother believes I'm sick because I'm possessed by a ghost. So, she took me to a temple for an exorcism. I didn't want to go there but my mother forced me.

FM3: She told her cousin she couldn't guarantee she won't attempt suicide. I'm doing my best to help her. I took her to a fortune-teller, who told her there's no love between her and her ex-boyfriend. He suggested she looks for another boyfriend.

Intervening conditions

The 'intervening conditions' in a model are known as the broader structural context pertaining to the phenomenon (Strauss & Corbin 1998). The 'intervening conditions' interact actively with the 'context' and 'action/interaction' sections of our model. Moreover, the 'intervening conditions' act either to facilitate or constrain the action/interactions strategies taken within a specific context (Strauss & Corbin 1998). In this study, one category was generated in the intervening section of the model, namely 'the provision of care in the home'.

Provision of care in the home

This category was reduced to three sub-categories (see Figure 2).

Support systems. Some participants reported that ex-patients received support from a range of different people such as family, friends, religion, healthcare professionals, mental counselling hotlines and social personage. These support systems facilitated the provision of caring. Some examples follow:

P3: I can't control my suicidal ideas. I'm really suicidal when I'm alone, I can see no way out, except when I realize my family is supporting me. This helps me.

P11: I call my former girlfriend when I'm upset. She's a Christian and she teaches me how to pray. She also prays for me. I also called the Samaritans once.

Conversely, when families or ex-patients perceived that they were receiving very little external support or were unaware of available support, they felt 'isolated' and 'alone'. Other family carers felt that they were 'too busy' to care for their relatives. These intervening conditions constrained the caring process. Two participants had this to say:

P2: I don't get support from other family members because they have to work and we don't live together. I've only got my son but we rarely talk because he needs to go to school and work. It's so lonely living in my head.

FM6: I've no time to care for my wife because I need to work from 7 AM to 5 PM. When I come home after work, I need to prepare food for my children and do housework. So, I've no time to care for her. If something goes wrong, I'll just send her to hospital.

Coping mechanisms. The most common coping approaches used by families to facilitate the caring process were action-oriented (keeping busy or pursuing interests), for example chatting with friends, exercising, and watching television. Other coping strategies used were relaxation, ignoring, religion and 'letting nature take its course':

FM15: My interests can help stabilize my mood. For example, I will play piano to help me. Recently, my new interest is to pick up driftwood (heavy wood) because it makes me tired and the wood fills my empty heart.

FM3: When I feel stressed, I repeat the name of a Buddha (Guan Shr Yin Great Compassion Bodhisattva). When I keep repeating that name, my emotions pacify.

Conversely, many families thought that they lacked the coping mechanisms required to care for their member who had attempted suicide. Most participants perceived that families had a deficit in knowledge about caring or did not have the physical strength because they were old, sick or 'dog-tired'. These intervening conditions constrained the caring process:

FM13: I read her diary and saw that she wanted to attempt suicide by hanging. I'm afraid to ask her because I worry I'll put the thought in her head.

FM9: I'm so dog-tired of it all. I'm the one who's caring all the time. There's no one there for me.

Helping skills. A few family members thought that their ex-patient member was willing to receive help from them, and a number of the ex-patients ($n = 6$) also wanted to recover from their ordeal. Hence, they were willing to accept help. Helping skills included the communication channels used in the home, which were open when the intervening conditions facilitated the process of caring:

FM11: Brian is still going through a very bad patch but he knows he has to try so he gets up in the morning and does the normal things in life like shaving and showering and eating.

P3: I think I can recover with my family's help. I rely on them. They're good to me. They listen to me.

On the other hand, many family carers perceived that it was difficult to offer helping skills for the suicidal ex-patients, especially when the communication channels were closed. Many former patients found it difficult to communicate with their families or others. Some struggled with listening to their families 'preaching' or 'scolding' them. Some resented the fact that they had been 'put in hospital' and their families had not

discharged them. Others would not take their medication because of side effects. Many family carers found it difficult to understand ex-patients' thoughts and had previous experiences of them concealing their suicide intent. A few former patients attempted suicide at night when family carers were asleep. These intervening conditions constrained the caring process. Three narratives depict these findings:

FM10: It's difficult to prevent suicide because you can't get close to her when something's wrong. She closes herself into her room and I think she starts to contemplate on how to commit suicide. I can't communicate with her.

FM6: She forced me to have her discharged from hospital. She told me she would attempt suicide if I didn't and that she would die in hospital. I wanted her to stay in longer. Now she resents me for that.

P13: I know my sister takes care of me but she doesn't listen to me. She always preaches to me. For example, she says: 'Why do you always have tunnel vision? If everyone was like you, we'd all be dead in the world'. When she talks to me like that I feel uncomfortable.

Discussion

It is difficult, if not impossible to understand someone else's despair, unless we ourselves have journeyed into the depths of human suffering. Even then, our despair is different from that of others, because it belongs to each one of us individually. It is complex to care for someone who wants to end their own life, because sometimes we feel impotent and are afraid, perhaps, to admit our own vulnerabilities. The data generated with families in this study support these notions. Suicide touches, or should touch, all of us at a very deep level because collectively we have failed to protect some of the most fragile people in society. The findings in the context section of the paradigm model (Strauss & Corbin 1998) illustrated the importance of families creating a warm and safe home milieu, which included providing a safe environment, promoting healthy relationships and preventing the family's mood from deteriorating into anger, numbness, anguish and fear. Nine of the ex-patients in this study still had suicidal ideas following discharge from hospital. Therefore, it is important for families to restrict such people's access to the most commonly used methods of attempting suicide, which in Taiwan are hanging and poisoning by burning charcoal (Department of Health, Executive Yuan, Taiwan, ROC 2007). However, our findings study indicated that it was difficult to provide a completely safe environment because ex-patients were free to leave their homes whenever they chose. Evidence shows that in Taiwan the top suicide prevention strategy used by relatives of psychotic patients (n = 276) was taking their relatives to hospital when they were in an adverse condition (Su 2003) and families perceived that there relatives were safe in psychiatric wards (Sun *et al.* 2006b).

In the current study, all of the family carers experienced negative emotions when caring for their suicidal relative. Feelings of stress, tiredness, anger and also anguish and numbness were the most frequently expressed emotional disturbances. These findings support those of Ekwall *et al.* (2007), who concluded that caring for another person is stressful both emotionally and physical. The more often the person attempts suicide, the higher are the stress levels in caregivers. Further, 90% of all cases of suicide are co-associated with a mental disorder, particularly depression and substance abuse (World Health Organization, 2007). Related evidence is found in Ip and Mackenzie's (1998) qualitative study, illustrating that Chinese family carers (n = 8) felt distressed, which encompassed a range of painful feelings such as anger, disappointment and frustration. Nurses have an important role in providing information on stress management techniques, self-care and self-nurturing to family members prior to their relatives being discharged into their care following a suicide attempt.

In the current study, family carers used only a few coping mechanisms; these were action-oriented, such as keeping busy or gathering wood until they were physically tired and ached from the heavy weight they were carrying. Many just told themselves to 'let nature take its course' and perhaps 'the situation will turn out all right'. However, these coping mechanisms did not work fully for them. Hence, many family carers still endured painful caring experiences. Ekwall *et al.* (2007) concluded that stress may, to a great extent, be dependent on caregivers' coping strategies, and that stress itself increases when using coping strategies that are not effective. The literature gives more evidence of coping strategies which family carers could use, including: (1) physical coping strategies such as neuromuscular relaxation and getting more sleep; (2) psychological coping strategies such as positive thinking, acquisition of knowledge, problem-solving techniques; (3) action-oriented coping strategies such as keeping busy or pursuing interests; (4) emotional strategies such as crying or ignoring and (5) social coping strategies such as seeking support from anyone and any place (Solomon & Draine 1995, Chakrabarti & Gill 2002). The collective evidence reveals that nurses have a pivotal role in teaching family carers coping strategies in order to promote and maintain their well-being.

In the current study, over half of the participants received support from a range of people, but fewer than half were not

What is already known about this topic

- Families have an important role in caring for a member who is at risk of suicide.
- Families use a wide variety of coping mechanisms when caring for a family member who has a mental illness.
- Chinese culture deems suicide a stigma and family members feel ashamed of their relatives who attempt suicide.

What this paper adds

- When caring for a member who is suicidal, family carers experienced a wide range of emotions from 'feeling tired' to 'being numb'.
- They used action-orientated coping mechanisms, including external support systems, internal coping mechanisms and helping skills.
- Nurses could provide therapeutic interventions, such as 'brief focussed' therapy to facilitate family carers to move forward and to validate the painful feelings they are experiencing during this life crisis.

supported by anyone. Family carers who received support felt better able to care for their relative who had recently been discharged and the ex-patients felt better able to cope in the home environment. Consequently, it is important to inform families of the statutory and voluntary support available in the community. In particular, the media could be used to inform the population of organizations such as the government-supported Taiwan suicide prevention centre. The centre offers help to individuals who have attempted suicide and their families (Lee *et al.* 2006). Staff at this centre plan to standardize the national suicide report format and care delivery system, improve the quality of the mental health service, and organize community support networks. Such centres have a crucial part to play in reducing the rapid rise in suicide rates.

Many family carers in this study chose other support systems, such as folk therapy or consulting psychics, requesting help 'to banish demons' from the person who had attempted suicide. These forms of help are associated with the Chinese culture, which relies heavily on the concepts of fate or destiny to explain happenings in people's lives, particularly when these life experiences are linked with unexpected problems. Chinese people believe that everyone can transform bad luck into good luck if they please the gods. These findings corroborate those of Tzeng and Lipson (2004), who conducted an ethnographic study and interviewed patients (n = 34) and family members (n = 49) to investigate the cultural context of suicide stigma in Taiwan. Their findings showed that some family carers believed that patients' suicide attempts were associated with patients' bad luck, which was also linked with being possessed with a ghost. Therefore, people sought folk therapy to eliminate their bad luck, as well as the stigma which is associated with suicide. It is important for healthcare professionals to have a sound knowledge of patients' cultural beliefs because these beliefs could prevent patients from taking their prescribed medications.

Study limitations

This study had three key limitations. First, there were difficulties involved in collecting data on this topic in Taiwan because of the collective, cultural shame regarding suicide and suicide attempts. Consequently, it took 1 year to collect data from the 15 suicidal ex-patients and the 15 family carers. Second, only 12 participants were interviewed in the family home because some family carers preferred to be interviewed in hospital. It would be interesting to explore if there are any differences in ex-patients' outcomes when their family carers perceive they are unable to invite a researcher into their homes. Third, only three ex-patients were men and more men should be included in future studies.

Conclusion

This paper goes some way towards adding to our understanding of the family care of suicidal ex-patients at home. However, it is practically impossible to imagine the pain family members must feel when one of their relatives either attempts or commits suicide. This situation, coupled with the distress experienced by former patients who had attempted suicide, portrays graphically the crisis in the family. Further, when the cultural, societal and religious or non-religious beliefs have an impact, this crisis is magnified.

Nurses have a fundamental role in providing information and teaching to all family members. This could be delivered in the form of an evidence-based, culture-sensitive, psychoeducation programme, which could include: attitudes and beliefs about suicide; protecting ex-patients' safety; using the available support and resources; promoting effective, open and caring communication; and the importance of self-care and self-nurturance. Ideally, nurses should offer therapeutic interventions to the family, such as 'brief focussed' therapy to help them to move forward and to validate, or 'normalize',

the range of painful feelings they are experiencing during this painful life crisis.

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Author contributions

FKS was responsible for the study conception and design. FKS performed the data collection. FKS, XYH and HMH performed the data analysis. FKS and AL were responsible for drafting of the manuscript. FKS and AL made critical revisions to the paper for important intellectual content. HMH provided statistical expertise. FKS obtained funding. FKS provided administrative, technical or material support. AL supervised the study.

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