Not a Time to be Silent: Suicide in Nursing

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Introduction

When I reminisce about the nurses I have lost along my career, I remember them as bright shining stars, veteran nurses full of wisdom, new nurses, nursing students, and up-and-comers, each filled with compassion and passion. Some were beautifully broken, making them better nurses who exuded more empathy. Some passed related to natural causes, cancer, the pandemic, or delayed access to a broken, overwhelmed healthcare system. However, too many were from suicide completion, and others from substance use, which led to intentional or unintentional deaths. Though the person completing suicide is at peace, those left behind must deal with the guilt, anxiety, grief, sadness, and confusion, amongst a myriad of other emotions and feelings, wondering how no one saw it coming. Wondering "what if?"

Current Literature

Multiple studies here and globally show that suicide rates among nurses are significantly higher than in the general population, with female nurses having a notably higher risk. It is broadly documented in the United States and the United Kingdom that female nurses have twice the suicide rate of females in the general population (Chan et al., 2024; Choflet et al., 2021, 2022; Davidson et al., 2020,2024). Think about that for a second. Let that settle in—twice the suicide rate. Male nurses have a similar occurrence to that of the general population in some studies. However, Usher (2023) found that men in nursing and in midwifery were 52% more likely to commit suicide than men in other occupational groups. Studies are all retrospective and likely underreported. Overdoses are often not part of these statistics as they are considered "accidental" (Schimmels et al., 2023). Additionally, we know that many suicide completions by nurses are those who were already having work trouble, may have lost their positions, were unable to control chronic or acute pain adequately, and may have lost or surrendered their license (Davidson, 2024). These are also not counted in the statistics.

Groves et al (2023) discuss the lack of studies focusing on the issue. There were no full systematic reviews. With an increased risk of substance use, nurses tend to attempt suicide by poisoning rather than by firearms, hanging, or strangulation, which the rest of the population uses. In their systematic review on suicide, self-harm, and suicide ideation in nurses and midwives, there were a total of 73 articles eligible for inclusion. An additional 27 were hand searched. COVID-19 studies were separated. Of interest, the studies Groves et al. (2023) reviewed, looking at prevalence, showed female nurses being at higher risk for suicide in the United States, Norway, England, and Wales, while Swiss and Canadian male nurses were at higher risk. A study from Oceania, Australia, and New Zealand showed increased suicide rates among nurses.

Even before the pandemic, the nursing profession was known to be at high risk for burnout, post-traumatic stress disorder, and suicide (Maben, 2022; Zohn & Hovis, 2024). Post pandemic, studies show an increase in terms of moral distress, compassion fatigue, burnout, emotional exhaustion, and PTSD with systemic challenges and unhelpful support (Maben, 2022; Shimmels, 2023; Usher & Jackson, 2023; Zohn & Hovis, 2023). Numerous studies have examined behavioral health, well-being, and risk factors for suicidality among nursing professionals. Our profession and our schooling in and of themselves are risk factors (Bilog, 2024; Nguyen et al., 2025; Paidipatie et al, 2023).

Risk Factors

Nurses are exposed to a unique combination of psychological, physical, and environmental stressors that increase our vulnerability. We work in high-stress en-

vironments with long hours, consecutive shifts, understaffing, and heavy workloads, which can lead to moral distress, burnout, and emotional exhaustion. With our repeated exposure to trauma day in and day out, we witness patient suffering, illness, death, and often must shift our care from curative to comfort or palliative, embracing care to the family. This too can lead to moral distress and compassion fatigue. There is difficulty in finding a work-life balance with demands coming from all directions. To err is human, but not in nursing. Patient Safety incidents that occur daily, with nursing being overly self-critical, create two victims: the patient and the healthcare worker (Stoval & Hansen, 2021; Werthman et al., 2021). With harm to a patient, a nurse is 20% more likely to commit suicide after a patient safety event despite work toward a culture of safety (Bilog, 2024; Stoval & Hansen, 2021).

Workplace violence and bullying are also unfortunately a constant, as well as a risk factor for suicide (Lu et al., 2022). Verbal and physical assaults occur to 81% of nurses. There are now reports confirming the underreporting of workplace bullying and violence, and that 8 out of 10 is still probably underreported (Joint Commission, 2016, 2021; National Nurses United, 2024). This contributes to suicide risk and a sense of isolation in toxic work environments. There has been an increase in workplace violence reports since COVID-19. Workplace Violence is a whole subject on its own but is a major contributor to suicide risk in nursing (American Hospital Association, n.d; Lu et al., 2022).

When looking at the factors influencing risk of suicide, studies related to mental health and well-being are considered. Nurses who have completed suicide were more likely to have a psychiatric disorder (personality, comorbid, and previous self-harm). In a study done in the US, the comorbidity of PTSD and depression was associated with suicide risk (Li, 2024; Roberts et al., 2020)

Finally, because of what we do, we also have access to and knowledge of lethal means. Most suicides are substance-related in female nurses, with a mix of findings in male nurses, including firearms (Choflet et al., 2021; Petrie et al., 2023; Schimmels et al., 2023). We have a culture that stigmatizes behavioral health needs and provides limited safe spaces for nurses. It is improving, but the issue remains. Many employers offer employee assistance programs, but they often go underutilized. Other employers only provide help within the healthcare system where the healthcare worker practices.

Further, the awareness of suicide among physicians and first responders gets immediate attention, while the high suicide rates in nursing go unrecognized (Usher, 2023). During COVID-19, there was a period where suicide became prevalent, and a physician's suicide led to the passage of the Dr. Lorna Breen Act (2021). This act provided funding to healthcare entities to develop programs to assist with mental health and well-being. The Dr. Lorna Breen Act (2021) supported $103 million dollars in American rescue Plan funding. Through the HRSA Health and Public Safety Workforce Resiliency Training Program, in 2022, The University of New Mexico received $2.2 million of those dollars over three years (HRSA, 2022). Unfortunately, several nurses in New Mexico have completed suicide or have had unintentional overdoses since that time. Outreach work must continue to support nurses in crisis.

Comprehensive multilevel initiatives are needed to support and maintain nurses' health (American Hospital Association, n.d.; James et al., 2024; Schimmells et al., 2023). This begins with each of us prioritizing our own well-being while advocating for systemic change. Professional organizations call for legislation addressing mental health drivers at organizational and regulatory levels. Yet, regulatory practices—such as licensing questions on mental health—discourage transparency, treatment-seeking, and mistake-reporting for fear of stigma or career consequences (Davidson, 2021).

We must advocate for ourselves as strongly as we do for our patients. Leadership should recognize the need for mental health days, safe spaces for debriefing, team check-ins, and support for staff in crisis. Bullying, workplace violence, and incivility must no longer be tolerated. High-risk and "Deathscape" areas (Maben, 2022) require proactive support, not reactive measures. While nurses are quick to give, we must also learn to receive care and create a culture where well-being is protected and prioritized.

Closing Thoughts

Nurses have been the most trusted profession annually since being added to the Gallup Poll, except in 2001. But this trust comes at a cost. As the largest provider of care, we are also the largest expense—and often the first to face cuts. Reduced staffing increases patient loads, diminishes support, heightens exposure to abuse, and intensifies job pressures (Sofer, 2021). When staff are not cut, supportive programs are, including orientation and competency training, leaving nurses to feel inadequate, morally distressed, and unsupported (American Hospital Association, n.d.; Davidson, 2021).

Frontline staff often feel unheard regarding safety concerns. Even with adequate staffing, long hours and high-stress environments take a toll on mental health, especially in constant "deathscapes" or trauma areas where nurses make life-altering decisions daily (Bilog, 2024; Maben, 2022). We must address these risks—our profession and the future of healthcare depend on it. Suicide drivers include stigma around seeking treatment, job-related stressors, and lack of access to credible mental health resources.

Ultimately, nurses must do better

Current resources: (Goal to increase care specifically for nurses!)

- 988 Suicide and Crisis Lifeline: Call or text 988 to connect with a trained counselor
- Crisis text line: Text FRONTLINE to 741741 to connect with a crisis counselor for free support.
- The Well-Being Initiative: The American Nurse Foundation offers a variety of resources to support nurses' mental health
- The Emotional PPE project: Nonprofit providing free, confidential therapy to healthcare workers.

at recognizing warning signs, knowing resources, and supporting each other through moral distress. We entered this profession to serve, provide care, and uphold dignity. In return, we too often face long and irregular hours, unsafe staffing, limited support, relentless emotional demands, and strained work relationships—all of which contribute to burnout and psychiatric conditions (Dall'Ora et al., 2020; Groves et al., 2023).

I hope each of you is doing something for yourselves today. Take a moment to be grateful. Take another moment to say thank you to someone you appreciate working with or supporting you.

I want to call out specifically on Maben's article in the references. This article validated so many feelings for me. I felt understood, and now I know I do not stand alone.

Signs of Suicide Ideation

Warning signs of suicide from the National Institute of Health (n.d) are seen throughout the literature. Please take a second to check in with your peer or coworker and see if they have any of these signs:

- Talking about wanting to die
- Discussing their guilt or shame
- Apologizing for being a burden
- Feeling empty, hopeless, trapped, having no reason to live, extremely sad, more anxious, agitated, rage, unbearable emotional or physical pain
- Changing behavior
- Researching ways to die
- Withdraw from friends
- Give away items
- Saying goodbye
- Preparing will
- Risk-taking
- Mood swings
- Eating or sleeping more or less
- Drugs/alcohol

What can we do?

Speak up and Advocate

- Safe Harbor
- Safe staffing issues
- Listen mindfully
- Disallow subpar training
- Hold dismissive leadership accountable
- Report retaliation for expressing concerns or pointing out unsafe practices
- Require suicide prevention training
- Ensure a safe environment
- Develop peer support programs- most of us want to talk with others who have shared experience
- Create systemic change
- Destigmatize the need for mental health care
- Call people out on bullying
- Do not partake in bullying
- Support a nurse who was just verbally or physically abused
- Deter "unhelpful" support (Maben, 2022)
- Organize a suicide awareness event
- Zero Tolerance for workplace violence and bullying
- Treatment for the effects of workplace violence and bullying (Yossep et al., 2022) ■

References online:
myamericannurse.com/?p=421806

Generational Nursing in New Mexico

Pat Montoya, MPA, RN, co-chair of the History of Nursing in New Mexico Special Interest Group

New Mexico is a state made up of communities and families, often large extended families. As a result, the values of giving back and serving others is often seen in families across generations.

As we have begun the journey of working on the "The History of Nursing In New Mexico – On Whose Shoulders We Stand" we have seen families of nurses that exist in our State. By family of Nurses, we mean several generations or many members of the family becoming nurses. You might see three generations of Nurses, such as a grandmother, mother, and daughter/son: or an aunt, nieces, and cousins.

As part of the history of nursing effort, NMNA wants to identify and highlight some of these families in the work we produce. If you are a member of such a family or know of families, please let us know by contacting Pat Montoya at montoya_p@msn.com or the New Mexico Nurses Association office at (505) 908-0686.

Thank you and we look forward to hearing from you. ■