Nurses' experiences of patient suicide and suicide attempts in an acute unit

Suicide and attempted suicide in an acute unit can have a devastating effect on staff and other patients. Fiona Bohan and Louise Doyle describe nurses' experiences of such events and their perceptions of the support they were given after the incident

Suicide and suicide attempts in Ireland have increased significantly in the last 20 years. A psychiatric staff nurse working in an acute mental health setting has a high chance of encountering a patient suicide or suicide attempt during his or her career. The occurrence of an inpatient suicide or suicide attempt is a stressful and devastating event for psychiatric nursing staff (Billings 2003). Vicarious traumas are serious manifestations of workplace stress and can have substantial consequences for healthcare professionals. Support services are minimal for psychiatric staff at present and, as a result, recent reports recommend that staff support should be developed further. This study describes psychiatric nurses' experience of suicide and suicide attempts in an acute unit and explores their perceptions of the support they received after the incident.

Literature review

Suicide rates in Ireland increased from 6.9 per cent per 100,000 people in 1982 to 11 per cent per 100,000 in 2005 (Health Service Executive 2006). Similarly, rates of deliberate self-harm (DSH) have also risen. The recently published *National Strategy for Action on Suicide Prevention* (Department of Health and Children 2005) emphasises that a history of one or more acts of DSH is the strongest predictor of repeated suicidal behaviour, both fatal and non-fatal. The *Report of the National Registry of Deliberate Self-Harm* (National Suicide Research Foundation 2006) indicates that there were approximately 11,000 DSH presentations to emergency departments in Ireland in 2005. Of these, 14 per cent were admitted directly for psychiatric inpatient treatment while another 40 per cent were admitted to a ward of the same hospital for treatment of the medical consequences of self-harm. Although no figures are available, it is most likely that many of these patients were further referred on to psychiatric inpatient units once their medical problems were resolved.

Psychiatric hospital inpatients are known to be at high risk of suicide and attempted suicide (Powell *et al* 2000). Corcoran and Walsh's (1999) retrospective study of all sudden or unexpected deaths in psychiatric hospitals/units in Ireland from 1983 to 1992 found that 319 per 100,000 short-stay inpatients died by suicide. In England and Wales, 16 per cent of those who die by suicide are inpatients at the time of their death (Department of Health 2001).

Bultema (1994) argues that healthcare providers who work with psychiatric patients will inevitably experience a patient suicide at some point. Cooper (1995) similarly discusses the inevitability of nurses experiencing a patient suicide or suicide attempt, highlighting that psychiatric staff who encounter patient suicide experience intense emotional reactions. These may be heightened if they have to manage traumatised patients while they themselves are traumatised. In a study exploring the effects of patient suicide on nursing staff, Midence *et al* (1996) identified nurses' reactions to a patient suicide. These included sadness, frustration, shock, fear, anger and guilt. Similarly psychiatric nurses in a study by Joyce and Wallbridge (2003) reported feeling stressed, sad, shocked and emotionally upset following the suicide or attempted suicide of a patient. In a study of trainee psychiatrists' experiences of, and reactions to, patient suicide, Dewar *et al* (2000) reported that many participants identified the suicide as having a deleterious effect on their personal and professional lives.

Vicarious traumas are serious manifestations of workplace stress and can have substantial consequences for healthcare professionals, the healthcare system and consumers of health services (Robinson *et al* 2003). Midence *et al* (1996) suggest that coping with a patient's suicide may be one of the most difficult tasks for nurses. McLaughlin (1993) highlighted the need for professional counselling for healthcare professionals following a suicide. This call has been supported by the report of the National Task Force on Suicide (1998), which recommended that the aftermath and aftercare of suicide for professionals should include counselling. However, Pallin (2004) suggests that while there is a significant amount of research and information available about suicide in general, there is a paucity of research into the impact of a patient's suicide on staff members, and into the resources and supports required by staff members to cope with this traumatic experience. Consequently, this study explores psychiatric nurses' experiences of and reactions to a patient suicide or suicide attempt to elicit their perceptions of the support they received after the incident.

Method

This is a qualitative descriptive study which, through semi-structured interviews, describes nurses' experiences of patient suicide or attempted suicide and the support they received afterwards. A descriptive method was chosen for the study as Sandelowski (2000) suggests that it is the method of choice when straight descriptions of phenomena are required. Using a qualitative descriptive design allows the researcher to stay close to the data and provide unadorned description of events in the words of those who have experienced them. The study utilised a volunteer purposive sample of nine psychiatric nurses working on acute inpatient units within three hospitals in a large urban area in Ireland. Inclusion criteria included having worked in an acute psychiatric unit in the last three years and having experienced a patient suicide or attempted suicide during this time.

Permission to undertake this study was obtained from the director of nursing at each hospital and ethical approval was also sought and granted from the hospitals concerned where required. Once permission was granted to proceed, potential participants were contacted by mail with an invitation to participate in the study. The contact letter outlined the aim, purpose and method of the study and provided assurances of confidentiality to potential participants. The contact details of the researcher were also included. Nine

keywords

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> self-harm
> staff: attitudes
> mental health services

These keywords are based on the subject headings from the British Nursing Index. This article has been subject to a double-blind review.

nurses who met the criteria for the study responded to the invitation to participate and arrangements for data collection were then finalised with these participants who volunteered to be interviewed.

Semi-structured audio-taped interviews were conducted with the nine participants. Conducting a semi-structured interview with the use of an interview guide ensured that all relevant areas of interest were covered, but also allowed flexibility in the phrasing and sequence of the questions. The interviews were taped with the participants' permission to ensure the accuracy of data collected, and the researcher took field notes when required. Interviews lasted from 30 to 45 minutes.

Burnard's (1991) method of data analysis was used for this study as it aims to create a detailed systematic description of the themes and areas identified on reading and re-reading transcripts. This systematic data analysis involved the researcher open-coding the interviews. The open codes were then organised into broad headings and these higher order headings were then organised into final themes that incorporated all the data collected in the interviews.

Findings

Four themes emerged from the data analysis:

- nurses' experiences of patient suicide/suicide attempts
- nursing care following an incident of suicide/suicide attempt
- feelings experienced by nurses following a suicide/suicide attempt
- support for nurses following a suicide/suicide attempt.

Nurses' experiences of suicide or suicide attempts

All participants had experienced at least two incidents of suicide/suicide attempt in an acute unit. The degree of severity of suicide attempt was identified by participants who noted suicidal ideation and low lethality self-harm through to high lethality suicide attempts and completed suicide. One participant found that following a completed suicide on a ward, there was a remarkable increase in other patients on the same ward attempting suicide. This participant identified the impact that this had on staff as a result:

> *'The worst impact for me and for most of the staff was the ward profile following the suicide, as patients were playing up, and as a result of this staff got burnt out.'* Participant 4

Accounts from some participants suggest that patients attempting suicide selected times on the ward when the staff shift was changing:

> *'It was like a pretty serious attempt that he made and he picked a particular time when he knew the routine of the ward. He knew, I suppose, nurses would be in the office and away and it was a very, very serious attempt.'* Participant 6

Accounts from other participants indicated that meal times are also high risk.

Nursing care

Participants acknowledged the importance of an immediate assessment of the situation following a suicide/suicide attempt:

> *'You assess the situation and the severity of it, you're obviously going to start putting in place how you are going to overcome and keep this person alive.'* Participant 6

In particular, participants identified how being familiar with the policies and procedure in place for this type of incident was beneficial:

> *'Obviously, at the time, my reaction was to follow the protocol, follow the procedures I had learnt as a nurse and to work as a team with all the other nurses to try and save this person.'* Participant 4

Accounts suggest that the role of a psychiatric nurse is to provide a safe environment for those who have attempted suicide and issues regarding one-on-one nursing observations were mentioned:

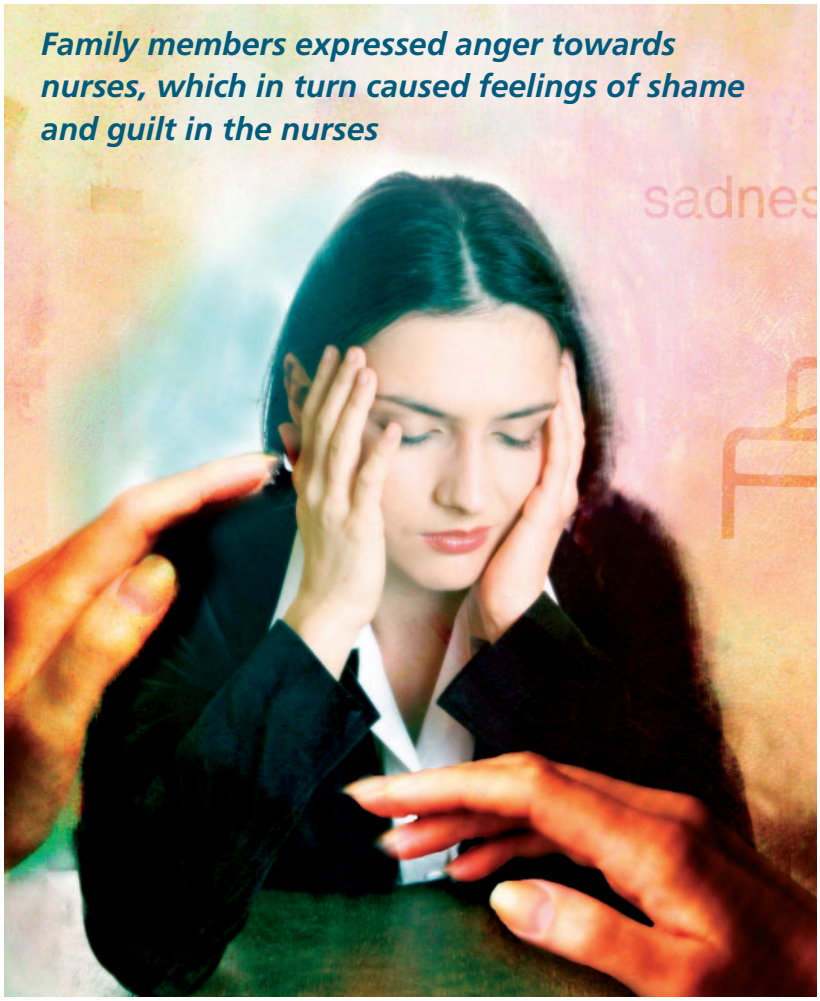
> *'That's your job as a psychiatric nurse, you know you are here to keep them safe and provide a safe environment.'* Participant 3
>
> *'I suppose the whole area of specialing, we looked at it at the time because eh … how long do you special someone who is suicidal?'* Participant 5

Accounts also suggested that some nurses became hypervigilant following such an incident in an attempt to prevent it happening again.

Nurses' feelings

Most accounts suggested that shock was the first feeling experienced by the participants. Anger was also identified as a prominent feeling. The anger was directed at the individual who had completed suicide or attempted suicide, and was a result of the frustration felt by the nurses who had invested time and effort in caring for the individual. Participants reported how family members expressed anger towards nurses, which in turn caused feelings of shame and guilt in the nurses. Frustration was mentioned by most participants and in some cases this was directed towards the individual:

> *'…quite angry and particularly with the girl that died because we had put so much effort into her and, eh*



Sarah Perkins

Participants identified the helplessness they felt in trying to comfort their colleagues and patients as they themselves were traumatised

> *… the anger I suppose was more out of frustration because so much time and effort had been spent with this girl and I felt that … we had failed her as well.'* Participant 5

Participants also reported feeling frightened, anxious and panicked following the experience. Accounts suggest the importance of experience when dealing with a suicide/suicide attempt and how the panic eases with experience, although one participant did identify the uniqueness of each situation when it happened:

> *'It's a highly traumatic event ... it's a new client, it's a new personality, it's a new set of circumstances, a new family, you know, so there's nothing the same about it, only that it's a tragedy.'* Participant 7

Participants identified the helplessness they felt in trying to comfort their colleagues and patients as they themselves were traumatised. They, in turn, were frustrated because they felt helpless:

> *'A sense of helplessness because no words can really, I suppose, are sufficient in those sort of circumstances so there was a huge sense of helplessness and frustration, I suppose – that would be the terms I'd use.'* Participant 5

Support systems

All participants identified that some form of support is crucial following such traumatic incidents and most participants felt that informal sessions were better for them. However, some participants felt that issues could be challenged more appropriately in a formal setting as it would be more focused:

> *'You could probably do it as an informal thing … sometimes it mightn't be that healthy … I suppose it may be seen as bitching more than anything else, if it's structured it can be challenged appropriately.'* Participant 1

The first support system identified by all participants is that of peer support and the vital role it has for nurses following a suicide or suicide attempt:

> *'The biggest help for me was kind of talking to my peers on the ward. I think that's the biggest help really, you know that you have the support from other nurses and they are going through a similar experience.'* Participant 4

This peer support was provided in a casual rather than a formal way but was very beneficial to participants nonetheless:

> *'I suppose I remember after it I went down and had a cup of tea and I had a chat with some of the staff there and that definitely helped.'* Participant 6

Family support was identified as useful by participants, although they only used it when something significant occurred:

> *'On this occasion I did mention it to my spouse and, you know, we talked a little about it and I felt that that was useful.'* Participant 7

In terms of more formal support provided by management, some participants identified the benefits of having a break from the ward immediately after the incident for at least a day or more, which was similar to the length of time nurses take for compassionate leave:

'People need the time to get away from it and they should be allowed some amount of time … you should probably get some sort of compassionate leave if you want it as well.' Participant 8

Some participants recalled times when they felt they were well supported by their line manager following an incident:

'Our immediate line managers came in and we were offered basic counselling, a debriefing session immediately … we were allowed to go off work, to go home, we got follow-up phone calls at home to make sure that everything was ok and everything, and we were offered debriefing over the next few days.' Participant 8

As well as talking informally about the incident with colleagues, participants identified the need for nurses to have protected time to help discuss the incident and to reflect on their practice. Participants identified the benefits that this would have for nurses and other members of the multidisciplinary team. Ongoing education was also identified as important by the participants. They suggested that specialised education about suicide and how to respond to an inpatient suicide would be beneficial as it would increase nurses' awareness of issues around suicide. Other participants suggested a team-building exercise following an incident and also a three or six-month post-incident analysis to ensure that staff were coping adequately with the after-effects of the trauma.

Discussion

All participants in this study had experienced at least two incidents of an inpatient suicide or suicide attempt. Many authors have highlighted the regular occurrence of suicidal behaviour in the psychiatric setting and have identified that most psychiatric nurses will experience some serious form of suicidal behaviour during their careers (Bultema 1994, Cooper 1995). Some participants in this study identified how the extent of suicidal behaviour on a unit increased after a suicide or suicide attempt by another patient. A study by McKenzie *et al* (2005) identified that imitative suicides occur among people with mental illness and may account for 10 per cent of suicides by current or recent patients.

Participants in this study identified increased vigilance after a completed suicide or suicide attempt on the ward and highlighted the importance of a sound knowledge of unit policies when responding to such incidents. Joyce and Wallbridge (2003) reported similar findings, with nurses in their study reporting increased vigilance, decreased trust in their patients and increased adherence to policy and protocol. Trainee psychiatrists who participated in the study by Dewar *et al* (2000) reported increased anxiety and difficulty in making decisions following a patient suicide and reported being over-cautious, specifically when deciding on observation levels, passes and discharge for inpatients.

Participants in this study also identified how the use of special observations or 'specialing' increased following an attempted suicide. Special or one-to-one observation is where a person is placed under the continuous observation of a nurse. While the practice of special observation is widespread in psychiatric inpatient facilities, its effectiveness is questioned by many. Cutcliffe and Barker (2002) argue that the therapeutic value of such special observation has long been questioned and describe it as a crude, custodial form of intervention to meet the highly complex needs of this patient group. Furthermore, they argue that it does little to address the crux of the patient's problems that led to

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the suicidal feelings in the first place. Studies have identified how, despite their close proximity, some nurses make little or no attempt to engage with the client while undertaking observation, and many patients report that nurses did not talk to them at all at such times (Jones *et al* 2001). Engaging with a patient who is suicidal or who is self-harming is a crucial nursing role and should be central to all nursing interventions.

The main feelings described by the participants in this study following an incident of suicide or a suicide attempt included shock, anger and frustration. Similarly, participants in the study by Joyce and Wallbridge (2003) reported anger, shock, fear, emotional upset, and irritability. Midence *et al* (1996) identified sadness, frustration, shock, fear, anger and guilt as the main feelings experienced. Dewar *et al* (2000) reported that trainee psychiatrists identified problems with anxiety, guilt, insomnia and loss of confidence. They also reported a continuing preoccupation with the suicide and how it could have been prevented.

Pallin (2004) suggests that a feeling of failure may pervade as the staff member's perception of self as a competent mental health professional may be challenged by a patient suicide. Pallin (2004) also suggests that feelings of blame, guilt and shame are also common among staff following the suicide of a patient. There is therefore a need for interpersonal and professional support for all staff involved in these traumatic incidents.

Participants identified the importance of talking as soon as possible after the event when the incident is fresh in everyone's mind. Farrington (1995) agrees with this response and explains that debriefing usually needs to take place within two days of the incident because the longer the time lapse, the more recall of the event becomes clouded. Interestingly, in Joyce and Wallbridge's (2003) study a third of the participants felt that debriefing sessions had been held either too early or too late following a suicide.

A strong finding to emerge from the present study was the importance of informal support from peers following an incident of suicidal behaviour. This is congruent with other research as 85 per cent of participants in the study by Midence *et al* (1996) identified how talking to a colleague or a partner about the incident was helpful. Similarly, 95 per cent of participants in the study by Dewar *et al* (2000) discussed the suicide of a patient with a team colleague and most found this to be 'often helpful'. However, an interesting finding in the study by Joyce and Wallbridge (2003) was that some participants believed that the incident had created a split among staff and had increased anxiety and tension among team members. While all participants in this study identified the importance of informal supports for staff, many also highlighted the need for more formal support from management – in particular, protected time for critical incident debriefing and reflecting on the incident were suggested.

Furthermore, participants also reported the need for team-building exercises following such incidents and for revisiting the incident three to six months later to ensure that staff are coping adequately. Of the participants in the study by Dewar *et al* (2000) only three-quarters discussed the suicide and its aftermath at a team meeting and less than half attended a critical review. While most of the nurses in the study by Joyce and Wallbridge (2003) reported that post-incident debriefing was important, some identified that those who appeared to be most affected by the incident did not attend the voluntary debriefing. This raises questions about whether debriefing meetings should be voluntary or mandatory. Pallin (2004) has suggested a four-phase system of supports that ought to be put in place following the suicide of a patient. These include immediate emotional and psychological support through to middle and longer-term interventions including the 'suicide review' or 'psychological autopsy' and training needs of staff.

Conclusion

Suicide risk is something that every psychiatric nurse is familiar with, but when a suicide or a serious suicide attempt occurs on an inpatient unit the sense of shock and trauma is palpable. While suicide risk assessment is a common role of the psychiatric nurse, suicide is often very difficult to predict, thereby heightening the emotional reactions experienced following the suicide of a patient. It is crucial that staff who experience a patient suicide or attempted suicide are provided with the relevant informal and formal supports to enable them to minimise the adverse effects of such a tragedy on their personal and professional lives and to help them reflect on and learn from the traumatic incident ■

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