Nurses' Role in the Prevention of Suicide

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Introduction

"Suicide is a death caused by an action initiated by a person with the intention of causing his own death." Suicidal acts vary considerably in nature: at the one extreme is the superficial gesture intended to manipulate the environment and at the other the determined fatal injury. The term (completed) suicide should be used only for the act which results in death. Although those who commit suicide do not become the concern of Nurses and Doctors, a knowledge of the various aspects may assist in its prevention.

A large proportion carry out their acts impulsively in a way that invites discovery and is unlikely to be dangerous. The term deliberate self harm (DSH) refers to the action of those who harm themselves and survive. Suicidal acts which do not end in death are described as suicidal attempts or as unsuccessful suicides (Para Suicide). Suicidal attempts have been estimated to be six to eight times as frequent as suicides. A history of suicidal attempt, therefore, increases the likelihood of suicide. The increasing deaths due to suicide require the attention of health care professionals to sort out effective measures for its prevention.

Prevalence

The overall annual rate of suicide in India was 6 to 9 per lakh in the late 1970s (Venkoba Rao: 1983) and around 12 per lakh in the late 1980s (Government of India Statistics: 1988). In Western countries studies have shown that suicide is the fourth leading cause of death in early adolescence (10-14 years) and the third leading cause in late adolescence and young adulthood. Suicide is responsible for 13% of deaths between ages 15 and 24 (Fauci *et al.*: 1997).

Incidence

The overall incidence of suicide in India has been found to be 6.8 per lakh. The annual rate of suicide in the cities of India ranges from 3.2 per lakh in Calcutta to 25.6 per lakh in Bangalore. The causes are largely social. (Government of India Statistics: 1988).

Studies conducted in India have shown the following results (Shukla *et al* : 1990, Unnie, S. *et al*: 1996) : Annual Incidence rate of suicide is higher for females when compared to males. Suicide rate is very high in the age group of 21-30 years for both sexes. Suicide occurred most commonly in the married (Western studies show that suicide rates are lowest among the married and more in the divorced, the widowers and the widows and the never married). Suicide rate is the highest in the population whose education standard is below the 10th standard and high in population above the 10th standard. Features of depression with hopelessness are found in more persons who committed suicide.

Modes

(1) Ingestion of poison-organo phosphorous, yellow oleander, drugs, kerosene, Phenol, etc. (2) Hanging, (3) Drowning — jumping into wells, ponds, rivers, etc., (4) Burning by kerosene, petrol, electricity, (5) Jumping from a height — from top of buildings, etc., (6) Getting run over by train, bus, etc., (7) Shooting.

Men are found to use more violent methods of suicide like getting run over by train, hanging, shooting and poisoning. Women usually prefer burning, drowning, poisoning and hanging.

Causes

Causes for suicide are mainly Medical and Social.

A. Medical Causes

I. Mental Illness

1. Depressive disorder : (a) endogenous or psychotic depression associated with delusions of hopelessness, guilt and unworthiness.

(b) Reactive depression associated with grief, loss, failure or social condemnation.

2. Schizophrenia associated with bizarre delusions or hallucinatory commands.

3. Alcoholism and drug dependence associated with a definite depressive illness, physical complications, marital problems.

4. Personality disorders : (a) Psychopathic personality associated with sudden impulsive behaviour, (b) hysterical personality associated with motives which may be nearer consciousness and the wish-to die not

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very strong but sometimes the attempt is carried too far and death results.

5. Organic brain disorders : delirium and dementia.

II. Physical Illness

Elderly people who have chronic physical illness are at risk (e.g., Pulmonary T.B., Bronchial Asthma, Epilepsy). Also, the following physical conditions have major contributing factors for the increased rate of incidence of suicide : (1) HIV infection, (20 Terminally ill Cancer patients, (3) Multiple Sclerosis, (4) Diabetes Mellitus with complications, (5) Myocardial Infarction leading to depression, (6) Mastectomy leading to total disfigurement, (7) Amputations leading to severe physical incapacity, (8) Neurologic disorders like CVA, Parkinsonism, (9) Chronic Pain.

B. Social Causes

(1) Domestic strife is the most frequent cause of suicide, e.g., harassment, beating or torture from in-laws and/or husband (at times for extorting dowry). Disturbed relationship (problems) with father, brother, wife, mother or stepmother. 2. Financial problems due to unemployment, poverty, loss of job, sudden economic or political crisis. 3. Bereavement (death of loved ones). 4. Divorce, broken homes. 5. Failure to have children. 6. Failure in examination. 7. Sexual abuse, rape, pregnancy before marriage.

Nursing Measures

Nurses' Role can be discussed under the following three headings : 1. In Psychiatric Hospitals or Wards, 2. In General Hospitals, and 3. In the Community.

I. In Psychiatric Hospitals

Recognition of the at risk suicidal patient is very important even though it may be difficult.

1. Recognition of underlying psychiatric factors, most commonly are depression, manifested by feelings of hopelessness, low self-esteem, despair and somatic complaints.

2. Substance abuse, alcoholism, family history of suicide, any history of psychiatric disorders, past history of suicidal behaviour need to be screened for suicide risk.

Once a suicidal patient is identified an extensive evaluation is required to assess the problem and inpatient care is appropriate for immediate management. The following actions need to be taken.

1. Establish a good rapport and a trusting relationship with the patient and encourage communication.

2. Help the patient clarify and explore the suicidal intention, ventilate sadness, anger, fear and unacceptable thoughts.

3. Make continuous and close observation of the patient round the clock. Every Shift Nurse must be aware of the suicidal risk patients.

4. Provide him or her a calm and noise-free environment.

5. Keep the environment free from potential dangers, such as, belts, razor blades, scissors, sharp objects; broken glasses, hanging wires; sarees, towels, ropes, bedsheets, etc.

6. Medicine should be supervised. Chances of the patient storing the drugs for future lethal ingestion are there. Always keep the drug cupboard under lock and key.

7. Never leave the patient alone in rooms. Toilets and bathroom locks should always be outside.

8. Fans should be at a height not reachable by any means. No electric switch or connection should be at a level reached by patient.

9. Careful observation of the patient and recording of communication with others should be maintained.

10. Observe the patient for any violence, hallucination, delusion, anxiety, panic, etc.

11. Physical restraint is usually avoided but sometimes needed with close observation.

12. Discuss with the patient about his or her suicidal thoughts and suicidal plans that will probably reduce his anxiety. Let him talk about his feelings of guilt and look for suicidal clues.

13. Promote and reinforce the feelings of being useful and needed and feelings of accomplishment. Promote decision making ability in her and establish a 'No Suicide Contract'.

14. Patients with history of suicidal attempts should be carefully observed and the Nurse should be vigilant to avoid further attempts.

15. Care should be provided for improving his personal hygiene, nutrition and sleep.

16. Take care of her physical problems.

17. Provide supportive and family therapy.

18. Organise rehabilitation and follow-up.

II. In General Hospitals

Patients developing signs of depression secondary to chronic physical illness have been reported to commit suicide and such deaths are on the rise. Nurses tactful in observing the early signs of depression from the at risk population can help in preventing deaths due to possible suicide by: (1) Prompt reporting to the treating team of any signs of depression such as feelings of hopelessness, worthlessness, diurnal variation of mood, insomnia, anorexia and weight alterations. (2) Talking with the patient; understanding and supporting her emotions in a caring and nonjudgemental manner. (3) Giving reassurance to the patient and

the family members. (4) Providing health education, counselling and guidance. (5) Giving individual and supporting psychotherapy, (6) Ensuring adequate family support in the aftercare. (7) Providing information to family members about the careful observation of the at risk patient, (8) Explaining social, vocational, occupational and recreational needs of the patient to be taken care of after discharge from the hospital. (9) Continuity of care, follow-up and rehabilitation of the at risk patient may be taken care of by a Community Mental Health Nurse. (10) Patients identified as risk group with suicidal ideas should be referred for psychiatric consultation.

III. In the Community

The community is the basic social unit through which the needs of the people may be met. The Government of India Statistics (1988) show that the major causes for suicide are social which indicates the need for more emphasis on community mental health.

Nurses are unique in their ability to bridge the gap between the hospital and the community, between the psychiatrist and the community care giver and between the public and other health care providers. Therefore, Nurses' role in community support service is primary.

Suicide is only preventable. Once completed it is no longer treatable. Therefore, the Nurse's role in prevention of suicide in community can be discussed under the three levels of prevention.

(a) Primary Prevention : The primary prevention has a vital role of ascertaining the at risk population and high risk situations wherein stressful life events are the precipitating factors. The Nurses could play a major role in identifying high risk groups and *preventing the incidence* of suicide in them. Some of them are :

(1) Identifying the problems of scholastic performance and emotional disturbances among school going children and giving timely intervention. (2) Ensuring an harmonious relationship among the members of the family and teaching healthy adaptive techniques at the time of stress producing events. (3) Providing counselling services to (a) adolescents and retired persons to pass through transitional crisis, (b) members of a bereaved family to accept the loss. (4) Giving corrective suggestions and guidance to the deprived groups to secure bio-phycho-social supplies (food, love, shelter, clothing, health, recreation, etc.) otherwise the deprivation of it leads to alcoholism, crime and mental illnesses. (5) Strengthening the social support of the frustrated aged and helping them to retain their usefulness.

(b) : Secondary Prevention : Nurses' effective role in the secondary prevention can help in *reducing the incidence* of suicide. It includes : (1) screening for the high-risk group, (2) cause finding and early referral, (3) early and effective treatment for the patient and, if necessary, for the relevant family members, (4) mental health education, (5) crisis intervention, (6) consultation services.

(c) Tertiary Prevention : The Nurses in the community are mainly involved in rehabilitation and follow-up services of the mentally ill. It has been reported that the risk for suicide by depressive patients is greater in the period immediately following discharge from hospital : a third or more occurring within 6 months of leaving (Temoche *et al* : 1964). Some of the activities of Nurses in the community may help in preventing the suicide by patients after discharge from Mental or General Hospitals. It includes : (1) social reintegration of discharged patients back into the community, (2) extending rehabilitation (medical, vocational, social and psychological) and administration of medication at the door-step of the mentally ill, (3) utilising the resources of the family and the community for a long-term rehabilitation.

It is now recognized that rehabilitation is a difficult and demanding task that needs enthusiastic cooperation from different segments of society as well as expertise, equipment and funds. Also, interventions at the earlier stages are more feasible, will yield results and are less demanding of scarce resources (Park, K : 1994).

Conclusion

Suicide is almost invariably under-reported. Even in countries where vital statistics are carefully recorded, the published suicide rates understate the truth, the real rate being probably higher by a quarter to one-third than given out (Slater and Rosh: 1986). In India most of the suicides that are committed in the community are under-reported. Community Health Nurses can help in bringing to light such deaths.

Suicide has remained the most outstanding example of a psychiatric phenomenon to which disturbances in social relationships make a direct contribution. With increasing social factors contributing to increased rates of suicide, more emphasis should be laid on community mental health and social support services. Help of the Government, NGOs and other agencies can be sought in providing services for the at risk population. 'Hot Line' services or suicide prevention centres available in some big cities counsel and help the at risk groups with suicidal ideations.

A startling new report on the Global Burden of Disease and Injury (GBDI) reveals that about 90 million

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people in India alone (more than the combined populations of Mumbai, Delhi, Calcutta and Chennai) will suffer from major clinical depression at some stage in their lives and it will be the second leading cause of death by the year 2020. This indicates the severity of the problem and the need for a Community Mental Health programme to provide comprehensive range of services to all members of the community and thereby preventing the higher incidence of deaths due to suicides.

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BRANCH AFFAIRS

KERALA

The Sistysixth East Zonal (Kerala) Branch Meeting of the TNAI was conducted at I.H.M. School of Nursing, Bharananganam on October 22, 1998. Rev. Sr. Josita Myladiyil, Administrator, I.H.M. Hospital, inaugurated the meeting in the presence of Sr. Rose Vypana, Zonal Secretary, Sr. Mary Varayathukarottu, Principal, Rev, Fr. Kuriakose Mampilly and more than 150 TNAI members from different units. Fr. Mampilly, the chief gust, talked elaborately on the topic 'Participation in Holistic Health Development'. The participants were enchanted by the cultural programmes presented by the Nursing staff. Mrs. Shija Mathew, Nursing Tutor, welcomed and Sr. Rose Vypana thanked the participants.

Rev. Sr. Josita Myladyil inaugurating the 66th East Zonal (Kerala) Branch Meeting of TNAI.