Preventing Suicides in Mental Hospitals

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SUICIDAL thinking can occur in a variety of life situations and mental illness. It is more prevalent in severe forms of depression. Every person has at one time or the other thought about suicide; some have openly expressed this wish. The depressed person who expresse his wish to die is certainly at a high risk. Suicide is always an emotive issue regardless of whether it happens at home or in a hospital. It also carries the moral and social dilemmas of human rights, the sanility (sacredness) of life, prevention, stigma and care. A hospital suicide can have a devastating effect both on families and the staff of the unit.

Definition : Suicide is a direct purposeful action taken by a person to end his own life.

Statistics: Suicide is a significant health problem. It ranks second to accidents as the leading cause for loss of life. In America, nine young people, under the age of 24, in every 100,000 take their own life. Twenty per cent of the total suicides are by alcoholics and drug addicts. In India, according to a particular study, 75% of the suicides have been committed by young people and the ones below forty years. During the past several years, the Bangalore city has gained distinction of being the 'Suicide City' of the country. The annual number of suicides is estimated to range from 600,000 to 900,000 in India. Women reportedly attempt suicide 2 to 3 times more than men. Minorities have a higher suicide rate than Caucasians. Elderly persons are more inclined to kill themselves than those in any other age group. People experience more stress in the months preceding suicide.

Causes contributing to Suicide

There are many causes which contribute to suicides. They are: prolonged illness, perceived mental decline, intense loneliness, hopelessness, deprived living situation, and severe guilt reaction following loss of a loved one. Suicide may be seen as a way to rejoin the deceased dear one. In paranoid states, the suicide may be an attempt to escape tormenting delusions. The most common internal conflicts in a suicidal person are those associated with murderous impulses towards one's beloved arising out of an actual or imagined rejection or abandonment, socio-economic status like sudden loss of property and economic insecurity, conflict around marriage choice, in-law's problems, and failure in examinations.

Methods of Committing Suicide

Many persons use physical methods, chemicals and poison, or less severe methods of self-destruction to commit suicide. The physical methods include hanging, burning, using cutting or piercing instruments, jumping from heights and drowning. Chemicals include poisoning, taking coma producing drugs and inhaling gases. In less severe methods of self-destruction, a person neglects himself, refuses to eat, participates in high risk sports, develops destructive eating habits, indulges in heavy smoking and excessive drinking.

Symptoms of Depression with Suicidal Ideas

A person having suicidal ideas will suffer with various symptoms:

Somatic symptoms: Anorexia, fatigue, muscle aches, lowered libido, insomnia, weight loss, early morning wakening, diarrhea or constipation, vague pains and hallucinations.

Work and other interest: Apathy about work and learning, decreased work capacity, social disinterest and underestimating compliance.

Motor symptoms: Agitation or retardation, seeking physical contact, proximity or touch.

Mood: Irritable, apathy, cries easily, feels bad and empty

Ideas: Cognitive processes slowed, memory loss, self preoccupation, focus on negative aspects of life, and loss of insight.

Feelings: Anxiety, guilt, pessimism, hopelessness, helplessness, loneliness, fear, depersonalization and anger.

Nursing Management, Nursing diagnosis and formulation of client care.

Nursing Diagnosis

Nursing diagnosis of depression with or without suicidal ideas may include a childhood history of loss, disturbed family relationships, and a history of characteristic thought personality, and behaviour patterns that increase vulnerability to depression, or there may be a

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current crisis or loss to which the client is responding with an acute depression.

Other assessments that may contribute to the Nursing diagnosis include:

(a) Verbal responses indicating low self-esteem, negative self-concept, feelings of guilt, and self-accusation.

(b) Varying degrees of altered mood state, feelings of dejection, hopelessness, helplessness, emptiness and anger.

(c) Changes in physical appearance and general health status in a negative direction.

(d) Verbal responses and behaviour indicating slowing of co-operative process and inability to produce ideas.

(e) Complaints of various physical symptoms and manifestations of physical signs which accompany depression, such as fatigue and low energy levels in a variety of situations.

(f) Decreased interest in personal, social, interpersonal, spiritual, financial and occupational activities.

(g) Statements of self-destructive wishes or plans.

Statements such as 'I am tired of living', 'I find no joy in going on', 'I want to die', 'I am no good', 'I am worthless', 'I want to kill myself', etc. should be taken very seriously. A death wish may also be stated in a more subtle form such as: 'You should not bother about me, I am a burden on everyone', or 'Don't do anything special, it is over anyway', 'This is the last time we may meet', 'This is the last dinner, I am going to attend', etc. Thus, nursing diagnosis relates to the quality meaning, and degree of depression, which are expressed by a wide variety of signs and symptoms that are not always easily assessed.

Client care goals

Long term goals for the client could include the following:

Statements and behaviour that demonstrate acceptance of self and a positive self-concept, behaviour with others that shows appropriate interdependence, and expresses hope and a desire to live.

Short term goals could include:

- Personal hygiene is managed without assistance after improvement.
- Anger is expressed overtly toward an object that elicits the anger.
- Physical symptoms are described less frequently and are less extensive over time.
- Loss of or separation from the loved object is worked through realistically.
- Strengths and limits are realistically spoken of and accepted statements indicate an increase in self-esteem.
- Feelings of guilt are resolved and are not described out of proportion to an event.
- Activities are resumed, or new activities started as an outlet for feelings.
- Feelings are expressed verbally to professional staff and their meanings are resolved.
- Statements and behaviour express hope and a desire to live.

Nursing Interventions related to Client care Goals

The nursing interventions for each of these nine goals are discussed as under. Crisis intervention principles apply to the suicidal person.

- It depends upon the behaviour of the person.
- Very alert observation.
- Everybody must know the case.
- Keep the patient busy in the ward.
- Keep the sharp instruments away.
- Never give the medicines in the patient's hands.
- Do not allow the patient inside the medicine room.
- Keep all the pesticides away.
- The environment must be free of noise.
- The activities must be within the limits.
- Avoid bright colours.
- Antidepressant drugs should be given regularly.
- Very careful observation and recording of communication with others.
- Taking the help from relatives.

Interpersonal Relationships

- Should help in building patient's self-esteem and a sense of worth.
- No demands on them.
- Recognising by seeking and wishing.
- Let them talk about their feelings of guilt.
- Keep routine activities in the ward simple.
- Initial stages mothering care is very important.
- No attention to be given to failure, rather ignore the failure.
- Be very non-judgemental.
- Focus on positive attitudes and foster positive feelings.
- Let the patient feel that the patient is respected.
- Observe for any typical patterns of depressive behaviour.

In this regard, Joan Ashton (1987) states that:

(a) Bad ward design inevitably leads to poor observation. This must be borne in mind when considering where to put patients at risk.

(b) A ward to care for suicidal risk patients is one in which routine tasks are carried out by unworried confident staff. The suicide rate rises if the staff is disturbed. This highlights a number of factors relevant to nurses. If several consultants admit patients to the same Unit, their different medical requirements cause conflict.

(c) In the pre-suicide phase, the patient sometimes exhibits violence towards the staff. If the staff are stressed they may react with some verbal, even non-verbal cues and disturb the equilibrium in the ward, thus precipitating the suicide rates.

(d) Lack of continuity of staffing or several doctors admitting patients simultaneously, will also disrupt the Unit's stability.

It was decided from these observations to draw up a criteria that could help the nurses identify a potential suicide patient who had not necessarily voiced suicidal intentions.

Criteria Used to identify Potential Suicidal Patients in the Mental Hospital

Age 20-60 years, young male schizophrenic and middle aged depressive male or female: when consultant is on leave, change of ward/bed location, length of admission time and repeated admission are the criteria.

Action to be taken by Staff

(a) Survey notes and note any previous suicide attempts. If previous methods of attempted suicides are known, the opportunity to repeat can (it is hoped) be avoided.

(b) Identify risk patients and inform staff.

(c) Support relatives.

One can never underestimate the devastating effects that a suicide incident has either on the family of the individual or on the staff of the Unit. It is hoped that the above criteria can help prevent such an event in an acute admission unit.

Rehabilitation and counselling centres

Suicide prevention centre was established in 1958 at Los Angeles by two clinical psychologists, Norman.L. Feberow and Edwin S.Shneidman. The centre and its ambitious goals were supported by federal funds. Three aspects of suicide prevention became its major goals. These were:

(a) Saving of lives by identifying pre-suicidal persons and bringing them help;

(b) Using community resources to accomplish this goal; and

(c) Research into the total problem of suicide.

As a result of their practice and research, these psychologists are now firmly convinced that suicide is preventable because persons who think about and commit suicide give indications in advance and are basically ambivalent about suicide itself.

There are 7 rehabilitation and counselling centres at Bangalore. They are :(a) NIMHANS, (b) Medico Pastural Association, Pottery Road, (c) CAFM Treatment Centre, Bannerghatta Road; (d) Atma Dharshan Yogashram, 7th Block, Jayanagar; (e) Christian Counselling Service, Richmond Town; (f) Helping Hands, Museum Road; and (g) 'Ashirvad', St. Marks Road.

Facts and Myths about Suicide

1.*Myth* : People who talk about suicide do not commit suicide.

Fact : Of any ten people who kill themselves eight give definite wordings of their suicidal intentions.

2.*Myth*: Suicide happens without warning.

Fact : Studies reveal that those who commit suicide give many clues and warnings regarding suicidal intentions.

3.*Myth* : People committing suicide are fully intent on dying.

Fact : Most suicidal people are undecided about living and dying and they gamble with death, leaving it to others to save them. Almost no one commits suicide without letting others know how he/she is feeling.

4.*Myth* : Once a person is suicidal, he/she is suicidal for ever.

Fact : Individuals who wish to kill themselves are suicidal only for a limited period of time., if they are helped appropriately they stabilise themselves.

5.*Myth* : Improvement following a suicidal attempt means that the suicidal risk is over.

Fact: Most suicides occur within about three months after beginning of 'improvements', when the individual has the energy to put morbid thoughts and feelings into effect.

6.*Myth* : Suicide strikes much more among the rich or conversely it occurs most exclusively among the poor.

Fact : Suicide is neither the rich man's disease nor the poor man's curse. Suicide is represented proportionately among all levels of society.

7.*Myth* : Suicide is inherited or 'runs in the family.

Fact : Suicide does not run in families. It is an individual pattern.

8.*Myth* : All suicidal individuals are mentally ill and suicide always is the act of a psychiatric person.
Fact : Studies of hundreds of genuine suicidal notes indicate that although the suicidal person is extremely unhappy, he/she is not necessarily mentally ill.

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