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Cite as: Bohan, F & Doyle, L, Nurses' experiences of patient suicide and suicide attempts in an acute unit, *Mental Health Practice*, 11, (5), 2008, p12 - 16

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## **Nurses' experience of patient suicide and suicide attempts in an acute unit.**

### **Introduction**

Suicide and suicide attempts in Ireland have increased dramatically in the last twenty years. Many of the presentations of suicide attempts to Emergency Departments are recommended an admission to an acute mental health unit. A psychiatric staff nurse working in an acute mental health setting has a high chance of experiencing a patient suicide or suicide attempt during their career. The occurrence of an inpatient suicide or suicide attempt is unquestionably an overwhelmingly stressful and devastating event for psychiatric nursing staff. Vicarious traumas are serious manifestations of workplace stress and can have substantial consequences for health care 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 aims to describe psychiatric nurses' experience of suicide and suicide attempts in an acute unit and explores their perceptions of the support they received post-incident.

### **Literature Review**

Suicide rates in Ireland have increased from 6.9% per 100,000 in 1982 to 11% per 100,000 in 2005 (National Office for Suicide Prevention 2006). Similarly, the rates of deliberate self-harm (DSH) have also increased. It is widely accepted that there is a strong link between deliberate self-harm and suicide. The recently published National Strategy for Action on Suicide Prevention (2005) emphasises that a history of one or more acts of deliberate self-harm is the strongest predictor of repeated suicidal behaviour, both fatal and non-fatal. The Report of the National Registry of Deliberate Self-Harm (2006) highlights that there were approximately 11,000 presentations to emergency departments in Ireland with deliberate self-harm in 2005. Of these

presentations, 14% were admitted directly for psychiatric inpatient treatment while another 40% were admitted to a ward of the treating 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. Corcoran and Walsh's (1999) retrospective study of all sudden or unexpected deaths in psychiatric hospitals/units in Ireland from 1983-1992 found that 319 per 100,000 short stay inpatients died by suicide. In England and Wales, 16% of those who die by suicide are inpatients at the time of their death (Department of Health 2001). Psychiatric hospital inpatients are known to be at high risk of suicide and attempted suicide (Powell et al 2000), and the figures above appear to support this contention.

Bultema (1994) argues that health care providers who work with psychiatric patients will inevitably experience a patient suicide at some point. Billings (2003) suggests that the occurrence of an inpatient suicide or suicide attempt is unquestionably an overwhelmingly stressful and devastating event for a psychiatric nursing staff. Cooper (1995) similarly discussed the inevitability of nurses experiencing a patient suicide or suicide attempt, highlighting that psychiatric staff who survive patient suicide experience intense emotional reactions. These feelings may be heightened as they may 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 some of the nurses' reactions associated with a patient suicide and these included sadness, frustration, shock, fear, anger and guilt. Similarly psychiatric nurses in a study by Joyce (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 impact on their personal and professional lives.

Vicarious traumas are serious manifestations of workplace stress and can have substantial consequences for health care professionals, the health care 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 health care 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 suicide on staff members and into the resources and supports required by staff members to cope with this traumatic experience. Consequently, this study will explore psychiatric nurses' experiences of and reactions to a patient suicide or suicide attempt and will elicit their perceptions of the support they received post-incident.

## **Method**

This is a qualitative descriptive study which uses semi-structured interviews to describe nurses' experiences of a patient suicide or attempted suicide and the supports they received after the incident. A descriptive method was chosen for this study as Sandlewski (2003) 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 in-patient 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. Exclusion criteria included being a Clinical Nurse Manager as it was felt that nurses in this post may not have the same 'hands on' experience of caring for the patient as a staff nurse might have.

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 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 ensured that all relevant areas of interest were covered through the use of an interview guide, 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 between thirty to forty-five 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 and are as follows: nurses' experience of patient suicide/suicide attempts, nursing care following an incident of suicide/suicide attempt, feelings experienced by nurses following a suicide/suicide attempt and the support for nurses following a suicide/suicide attempt.

### **Nurses' experience of suicide or suicide attempts in an acute unit.**

All participants had experienced at least two incidents of suicide/suicide attempt in an acute unit. The varying degree of severity of suicide attempt was identified by participants who reported 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.

**Participant 4:** *“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.”*

Accounts from various participants suggest that patients attempting suicide select times on the ward when the staff shift was changing.

**Participant 6:** *“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.”*

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

### **Nursing care following a suicide or suicide attempt**

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

**Participant 6:** *“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.”*

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

**Participant 4:** *“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”.*

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.

**Participant 3:** *“that’s your job as a psychiatric nurse, you know you are here to keep them safe and provide a safe environment.”*

**Participant 5:** *“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?”*

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

### **Nurses’ feelings following a suicide or suicide attempt**

Most accounts suggest that shock was the first feeling experienced by the participants. Anger was identified as a prominent feeling by participants. The anger was directed at the individual who had completed suicide or attempted suicide, the anger was also 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 the majority of participants, this frustration was directed towards the individual in some cases.

**Participant 5:** *“...quite angry and particularly with the girl that died because we had put so much effort into her and eh...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...”*

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.

**Participant 7:** *“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....”*

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.

**Participant 5:** *“a sense of helplessness coz 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.”*

## **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.

**Participant 1:** *“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....”*

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.

**Participant 4:** *“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.”*

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

**Participant 6:** *“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”.*

Family support was identified as useful from participants although they only utilised this when something significant occurred.

**Participant 7:** *“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”.*

In terms of more formal supports 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 leave nurses receive for

compassionate leave.

**Participant 8:** *“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.”*

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

**Participant 8:** *“our immediate line managers came in and they, 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”.*

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

## **Discussion**

All participants in this study had experienced at least two incidents of an in-patient

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% of suicides by current or recent patients.

Participants in this study identified an increased vigilance after a completed suicide or suicide attempt on the ward and highlighted the importance of a sound knowledge of the unit policies when responding to such incidents. Joyce (2003) reported similar findings with nurses in her 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 also reported being over-cautious specifically when deciding on observation levels, passes and discharge for in-patients. Participants in the present study also identified how the use of special observations or 'specialing' increased following an attempted suicide. Special or one-to-one observation is where the person is placed under the continuous observation of a nurse. While the practice of special observation is widespread in psychiatric in-patient facilities, its effectiveness is questioned by many. Cutcliffe & 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 them to feel suicidal 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 during the observation period (Fletcher 1999, Jones *et al.* 2001). Engaging with a patient who is suicidal or 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 (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 in their study 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 as 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 the memory recall of the event becomes clouded. Interestingly, in Joyce's (2003) study a third of the participants felt that the debriefing sessions occurred had been held either too early or too late following a suicide. A strong finding that came forward from the present study was

the importance of informal support from peers following an incident of suicidal behaviour. This finding is congruent with other research as 85% 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% 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 that emerged from the study by Joyce (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 supports which come 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 also revisiting the issue 3-6 months post-incident 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 the majority of the nurses in the study by Jones (2003) reported that postincident debriefing was important some identified that those who appeared to be most affected by the incident did not attend the voluntary debriefing. This raises the issue 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 supports 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 however when a suicide or a serious suicide attempt occurs on an in-patient unit the sense of shock and trauma are 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 this tragedy on their personal and professional lives and to help them reflect on and learn from the traumatic incident.

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