CARING FOR SUICIDAL PATIENTS IN THE EMERGENCY DEPARTMENT:
WHERE NURSING KNOWLEDGE FALLS SHORT

by

Dawn M. Benford

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SIGNED:______________________________

APPROVAL BY MASTER’S PROJECT DIRECTOR

This Master’s Project has been approved on the date shown below:

_______________________________________________________________________

Terri Farmer, PhD, MS, BSN, PMHNP-BC Date: 
Clinical Associate Professor
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ABSTRACT

Suicidal behavior is a major health problem with a high burden of disease, and patients with suicidal behaviors often seek care in general emergency departments where nursing staff is usually not adequately trained to assess and treat suicidal patients. Inadequate care of suicidal patients can have a significant effect on emergency departments and staff; therefore education is needed to improve attitudes of emergency department staff towards patients that harm themselves. Improved attitudes will foster increased knowledge of assessment and treatment of suicidal patients in the emergency department.
CHAPTER 1
Problem Statement

Emergency psychiatric services are inadequate in America, and general emergency departments are required to fill the void by providing psychiatric services to those in need. Unfortunately, emergency department staff is not usually trained to competently treat people suffering from psychiatric emergencies, such as suicidality. Psychiatric assessment is lengthy and difficult when compared to general medical assessments. Emergency department staff often have difficulty accessing consultations in a timely manner and community resources may not be available, especially during nights and weekends. Additionally, staff often do not know what resources are available to patients. Surveys of emergency medical personnel portray a variety of frustrations. Many respondents complained of a lack of inpatient psychiatric beds, which leads to the boarding of psychiatric patients in emergency departments for extended periods of time. Other emergency medicine providers voiced concerns about the adequacy of their assessment skills and the slow response times of mobile crisis teams. The ultimate effect is the increase in adverse outcomes when psychiatric patients are not appropriately managed.

Emergency departments and the people that seek care have suffered as a result of the mental health crisis in America. The National Mental Health Association (2004) reports that overcrowding of emergency departments causes serious delays in emergent medical and psychiatric treatment. In response to this crisis, people are being directed to inappropriate levels of care due to limitations in resources. (National Mental Health
In addition, emergency department nurses are usually not trained to deal with or recognize cues of increasing agitation in mentally ill individuals, which can result in difficult-to-control anger and violence. It is not uncommon for emergency department staff to quickly utilize very restrictive means of de-escalation, such as physical and chemical restraints, rather than less restrictive means, such as talking. (Lauer & Brownstein, 2008) Furthermore, emergency department nurses are trained to quickly provide adequate medical care to stabilize patients but often lack compassion for patients who present with psychiatric crises. (Camilli & Martin, 2005) In the current system, emergency departments are ultimately set up to fail and are at risk for litigation when sentinel events occur.

Failure to identify just one person at risk for suicide, who subsequently kills herself/himself exposes the hospital to significant legal risk. If a hospital is sued for negligence for the death of a patient to suicide the amount of financial risk depends on the deceased person’s work life expectancy, medical costs associated with the death, and the facts associated with the missed occurrence. (Giordano & Stichler, 2009) The fees can be in the millions of dollars range, and even if the hospital is not found negligent the costs of trial can range up to $75,000. (Giordano & Stichler, 2009)

Nursing staff in emergency departments are in a prime position to improve the acute management of patients that non-fatally self-harm. In June 2006, the Joint Commission on Accreditation of Health Care Organizations (JCAHO) approved new patient safety goals that require documented suicide-risk assessments for patients in acute
care hospitals. (Hospital and Critical, 2006) However, research shows that emergency department nurses need further suicide education to improve attitudes toward those who self-harm and to aid in effective suicide assessment and reduction. The ability of nurses to understand the prevalence and correlates of suicidal behavior is important for effective treatment of suicidal patients.

Purpose of Project

The purpose of this project is to address the need for increased education for emergency department nurses on the topic of suicidal behavior. Research shows that the need for treatment of suicidal behavior in general emergency departments is increasing, but there has not been a complimentary increase in nursing knowledge on the topic. This project will enhance the reader’s knowledge of suicide and it’s history, etiology, and risk factors. An extensive review of the literature will provide a summary of important suicidal correlates, as well as discuss the profound effect that suicidal behavior has on emergency departments. In addition, attitudes towards patients that present to emergency departments with suicidal behavior will be discussed to emphasize the importance of staff attitudes on adequate patient assessment and treatment.

The information in this project will be used to develop and implement a formal training program that focuses on improving the attitudes of emergency department nurses toward patients who self-harm and to improve the suicide assessment skills of emergency department nurses. There is little evidence that one suicide prevention strategy is more effective than another, however research has shown that health care professionals’
attitudes are a major factor in the prevention of suicide. (Chan, Chien, & Tso, 2008) In addition to improving nurses’ attitudes, educational programs can greatly increase knowledge and competence in suicide prevention and intervention in emergency departments.

Significance

Mental illness is the second leading cause of disease burden in the United States (Murray & Lopez, 2003), and visits to emergency departments for mental illness are abundant and growing. Importantly, people with a diagnosable mental illness, such as depression and/or substance abuse disorder, perform 90% of completed suicides. (Perhats & Valdez, 2008) Suicide is among the top 12 leading causes of death in America, accounting for 32,439 deaths per year, and it is the third leading cause of death among American youths 15-24 years of age. Suicide completion is higher in males than females and is the highest in white males over the age of 85 at a rate of 65 per 100,000. Suicide consistently exceeds the number of homicides in any given year in the United States. (Institute of Medicine, 2009) For every suicide death in America, it is estimated that there are approximately 800,000 suicide attempts. (Giordano & Stichler, 2009) From 1979 to 1999, 448,060 people in the United States died from AIDS and HIV complications: during the same time 626,226 people died from suicide. (Institute of Medicine, 2009)

Suicidal behavior is often preventable, yet it is a private and complex act. Common factors associated with suicide include: serious mental illness, alcohol and substance abuse, childhood abuse, loss of a loved one, fear, and economic hardship. This
is significant considering 28-30 percent of the U.S. population has a mental or addictive disorder. Even though 90% of suicides are associated with mental illness, 95% of individuals with mental illness do not commit suicide; (Institute of Medicine, 2009) therefore the challenge lies in accurately identifying individuals at the greatest risk for suicide.

The most successful method for suicide prevention is effective suicide assessment and intervention. In the United States of America, 90 people die from suicide daily while another 1800 American people make non-fatal suicide attempts that require emergency treatment. (Larkin, Smith, & Beautrais, 2008) Unlike the general population, patients who present to the emergency department with suicidal ideations or suicidal attempts are readily identifiable as being at high risk for further self-harm. Emergency department nurses are posed to provide suicide assessment, intervention, and prevention.

Emergency departments often serve as points for primary medical care for people that are uninsured, as well as other Americans that are at high risk for suicide. (Giordano & Stichler, 2009) However, emergency medical staff have voiced fears and concerns about their lack of education in treating patients that present for suicidal ideations and/or suicide attempts, which is problematic since approximately 5.4% of emergency department visits are for mental health problems. (Larkin, Smith, & Beautrais, 2008) Research also shows that emergency nurses might express negative attitudes towards patients that self-harm. As more Americans become uninsured or underinsured the emergency departments will continue to be primary treatment arenas for mental illness.
related problems.

**Suicide Continuum**

Suicidal behavior is categorized into three types: ideation, suicide attempts, and completed suicides. Suicide ideation is defined as thoughts of harming or killing oneself. The severity of suicidal ideation can be determined by assessing the frequency, intensity, and duration of these thoughts. (Suicide Prevention, 2002) Suicide attempts are non-fatal, self-inflicted destructive acts with explicit or inferred intent to die. (Suicide Prevention, 2002) Finally, suicide is defined as a fatal self-inflicted destructive act with explicit or inferred intent to die. (Suicide Prevention, 2002) A person might also engage in deliberate self-harm or para-suicidal behaviors, which is the willful self-inflicting of painful, destructive, or injurious acts without intent to die. (Clarke, Brown, & Giles-Smith, 2008) Data shows that the number of suicidal behaviors performed in the United States each year is significant, however the actual numbers of completed suicides and suicide attempts are most likely underestimated since many are reported as accidents or undetermined deaths. (Sokero et al., 2008) Many people have suicidal thoughts or ideations at some point in their lives, which can last for days, weeks, or years, without actually attempting suicide. Other people appear to impulsively commit suicide without evidence of a thought out plan.

**Risk Factors**

There is a wealth of available literature and knowledge on risk factors for suicide and Sadock & Sadock (2007) outlines several. Overall, men are successful in completing
suicide four times more often than women, however women are four times more likely to attempt suicide. Men are more likely to use methods with high lethality, such as firearms, hanging, or jumping from high places. Suicide has been shown to increase during the middle of life and peaks in men after age 45 and in women after age 55. People older than age 75 are at the highest risk for committing suicide at a rate of three times greater than younger people. Sadly, the rate of suicide is increasing most quickly in males between age 15 and 24 and is the third leading cause of death in this age group. Suicide is rare but not obsolete in prepubescent children. In general, white males and females are two to three times more likely than African Americans to commit suicide. Immigrant suicide rates are higher than native-born rates. Marriage is also correlated with suicide, in that married people are less likely to commit suicide, especially if they have children. However, divorce increases suicide risk and divorced men are three times more likely to kill themselves than divorced women. Occupation poses an interesting role in suicide in that higher social status increases a person’s risk of suicide, as does a sudden fall in status. Physicians, law enforcement agents, dentists, artists, mechanics, lawyers, and insurance agents are at significantly greater risk for committing suicide than those in other occupations. The risk is especially compelling for female physicians, psychiatrists, ophthalmologists, and anesthesiologists. Female nurses are also one and a half times more likely to commit suicide when compared with the general population. (Kelly & Bunting, 1998) Physical and mental illness are closely related to suicide and will be discussed in depth later in this paper.
Etiology of Suicide

In the late 19th century, Emile Durkheim presented his work on suicide and suggested that social characteristics determine a society’s suicide rate. (Tartaro & Lester, 2005) He separated suicide into three distinct categories: egoistic, altruistic, and anomic. Egoistic suicides occur when a person is too focused on self and does not have a strong relationship with a social group, such as unmarried people and people living in large urban areas rather than tight-knit rural communities. On the contrary, altruistic suicides occur when a person is overly enmeshed with a group of people. This type of suicide has four key features: a context of abnormally excessive societal integration; is generally marked by support from public opinion; it benefits society materially or culturally; and is often marked by positive emotionality. (Stack, 2004) People that commit altruistic suicide do so for something they love more than themselves. Anomie refers to people lacking control by society, and Durkheim explains that we need to be controlled by society because “every disturbance of equilibrium…is an impulse to voluntary death”. Anomic suicide occurs when sudden economic changes, whether positive or negative, disturb the equilibrium of a person’s life. “Whenever serious readjustments take pace in the social order men are more inclined to self-destruction (Fernquist, 2007).” Essentially, anomic suicide results from a change in situation that affects vulnerable individuals. (Sadock & Sadock, 2007)

There is an array of theories that propose psychological factors as the cause of suicide. For example, Freud expressed that suicide originates from an early-repressed
desire to kill someone else. Karl Menninger agreed with Freud suggesting that suicide is due to inverted homicidal ideations and the wish to kill, be killed, and the wish to die. (Sadock & Sadock, 2007) However, contemporary theorists argue against earlier presented theories. Today it is believed that suicide can be understood by learning about the fantasies surrounding suicide that people formulate. The desire for revenge, control, power, or punishment might underlie the suicidal patient’s inclination towards death. Recent loss and the need to be with the deceased can be a significant factor in suicide. A person with narcissistic traits might commit suicide as a result of injury to his/her pride. (Sadock & Sadock, 2007)

Biological and genetic factors also play an active role in the etiology of suicide. Research has implemented serotonin in suicidal behavior. Post-mortem studies on patients that died from suicide have reported low concentrations of serotonin metabolite 5-hydroxyindoleacetic acid (5-HIAA) and changes in presynaptic and postsynaptic serotonin binding sites. (Sadock & Sadock, 2007) Furthermore, there is strong evidence that suicidality runs in families. This is markedly supported by twin studies and adoption studies. Twin siblings are more likely to both attempt and/or commit suicide than non-twin siblings and adopted individuals that attempted and/or committed suicide were more likely to have biological relatives that also committed suicide than adopted individuals that did not attempt suicide. (Sadock & Sadock, 2007)

**Stress Vulnerability Model**

Psychiatry is a relatively new specialty, rooted in both social and biological
sciences, and the etiology of mental illness remains elusive. Scientists have developed many theories that struggle to explain mental illness, and one theory that has received significant support is the “stress-vulnerability model.” This theory suggests that both stress and biology contribute to symptoms of mental illness. “Biological vulnerability” refers to people who are born with, or who acquire very early in life, a predisposition to develop a problem, such as high blood pressure, diabetes, heart disease, or a mental illness like schizophrenia, bipolar disorder, or depression. (Stress-Vulnerability, 2009) It is well accepted that mental illness has a hereditary component, however some people develop mental illness with no familial history. Therefore, it is not adequate to contribute the development of mental illness to genetic factors alone. Researchers believe that stress plays a significant role in the development of psychiatric symptoms, and stress may play a strong role in increasing the biological vulnerability to depression. (Stress-Vulnerability, 2009) It is important to note that stress is perceived differently from person to person. What is perceived as stressful to one person may not be stressful to another person, but everyone will experience stress during his or her lifetimes. In a person genetically predisposed to mental illness stress can make symptoms worse or may trigger the onset of symptoms.

Within the framework of the stress vulnerability model, suicide attempts are prevented by using medications to reduce biological vulnerability and by reducing stress and increasing coping skills. It is accepted that mental illness has a hereditary component, and it is also believed that stress can play a significant role in the development and
exacerbation of a variety of mental illnesses. Treatment of mental illness guided by the stress-vulnerability model must address both biological and stress factors. Effective treatment of mental illness can decrease the number of suicide attempts by reducing biological vulnerability, reducing stress, and increasing coping. Psychotropic medications and avoiding drug and alcohol can reduce biological vulnerability, and stress reduction can help reduce symptoms. (Stress-Vulnerability, 2009)
CHAPTER 2

Introduction

This chapter will provide an overview of the history of suicide and an in depth review of the literature guided by the stress-vulnerability model. Mental and physical illnesses that correlate highly with suicide will be explored

History of Suicide

Suicide stems from the Latin word for “self murder” (Sadock & Sadock, 2007) and dates back to the beginning of time. Per Plato (429-348 B.C.), “It is only upon death that the soul, freed from corporeal existence, may aspire to the realm ‘of the gods and of the Forms, where perfect happiness reigns’”. In the times of Socrates, suicide was viewed as immoral and Socrates was asked by friends, “How do you mean, Socrates, that it is wrong to commit suicide, and yet that the philosopher would gladly follow one who was dying (Crone, 1996)?” Aristotle spoke of suicide as an act of coward, because it shows character weakness to escape hardships. Suicide appears to be rather rare in biblical times possibly “because it represented a dangerous form of spilling blood, a loss of community control over the blood of a tribal member, and the possibility of an unattended corpse in the wilderness (Crone, 1996).” However, there are documented cases of suicide in the Old Testament and the New Testament. Overall, suicide has been discussed throughout the ages and within the context of many religions and cultures.
Major Suicide Risk Factors: Review of the Literature

*Mood Disorders*

Mood disorders correlate highly with suicidal behaviors. In the general population about five percent of people with depression commit suicide and in the clinical setting the number rises to approximately 15%. (Dubovsky & Dubovsky, 2008) This is especially important for emergency department staff, because more than a third of the patients that receive treatment for a suicide attempt in the emergency department are diagnosed with depression. Hopelessness, which is one of the criterion for major depressive disorder is a consistent predictor of suicidal behavior. (Beck & Weishaar, 1990) In addition, more severe depression is associated with more suicide attempts, and most attempts occur early in the course of a depressive episode.

Among all the mood disorders the risk of suicide is highest in bipolar disorder and especially in mixed states when the patient is both depressed and manic. (Dubovsky & Dubovsky, 2008) Research shows that 20-50% of bipolar patients attempt suicide at least once in their lifetime and approximately 1% complete suicide, which is about 60 times the rate of the general population. (Fountoulakis, Gonda, Siamouli, & Rihmer, 2009) This mood state is particularly dangerous because the patient may have suicidal thoughts in association with a high level of energy and impulsivity. Methods of suicide attempts are often of higher lethality when performed by a person with bipolar disorder, which is supported by a much lower ratio of suicide attempts to completed suicides. This ratio is approximately 3:1 in bipolar patients and 30:1 in the general population. It is also well
accepted that bipolar disorder is highly inheritable, and a family history of suicide doubles the risk of suicide in patients with mood disorders. Inheritability of mood disorders may be in part due to the stressors that children of a parent with a mood disorder encounter, including marital discord, poor quality of parenting, and an unstable home environment. Chronic exposure to stress during life can greatly increase the risk of psychopathology in people already at genetic risk for a mood disorder (Ostiguy, et al., 2009), which is consistent with the stress-vulnerability model. Emergency department nurses need to be aware that the cumulative affects of chronic stress can negatively impact people at high risk for mood disorders and thereby increase suicidal risk.

**Schizophrenia**

Schizophrenia is a disorder characterized by two or more of the following symptoms: delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior, negative symptoms, such as affective flattening, alogia, or avolition. If delusions or hallucinations are bizarre only one of the aforementioned symptoms are required for a diagnosis of schizophrenia. The onset of schizophrenia is most often before age 25 and persists throughout life. When the onset of schizophrenia is precipitated by obvious stressors, as explained in the stress-vulnerability model, the prognosis is better than if the onset is insidious with no precipitating factors. (Sadock & Sadock, 2007)

Suicide is the leading cause of premature death among people with schizophrenia. (Caldwell & Gottesman II, 1990) In people with schizophrenia the lifetime risk of committing suicide is about 9-13% (Caldwell & Gottesman II, 1992) and the attempted
suicide rate ranges between 20% and 40%, which indicates a high level of distress experienced by people diagnosed with schizophrenia. (Meltzer & Okayli, 1995) However, it remains quite difficult to determine which patients are at the highest risk of committing suicide because only a small proportion (9% to 13%) of people diagnosed with schizophrenia actually do commit suicide. There is also a high frequency of major risk characteristics in people with schizophrenia who do not commit suicide. (Meltzer & Okayli, 1995) Patients with schizophrenia who are most likely to commit suicide are white, male, younger than 45 years, and within the first 10 years of disease onset. (Pinikahana, Happell, & Keks, 2003) The following table outlines epidemiological correlates of suicide that are categorized into less and more specific to schizophrenia.

Table 2.1. Epidemiological Correlates of Suicide: Less and More Specific to Schizophrenia

<table>
<thead>
<tr>
<th>Less Specific Correlates of Suicide</th>
<th>More Specific Correlates of Suicide</th>
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<tbody>
<tr>
<td>Male Sex</td>
<td>Impulsivity</td>
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<tr>
<td>Unmarried and Living Alone</td>
<td>Recent Hospital Discharge</td>
</tr>
<tr>
<td>Unemployment</td>
<td>Poor Adherence to Treatment</td>
</tr>
<tr>
<td>Drug and Alcohol Abuse</td>
<td>Agitation or Psychomotor Restlessness</td>
</tr>
<tr>
<td>Depressive Symptoms</td>
<td>Fear of Mental Disintegration</td>
</tr>
<tr>
<td>Hopelessness</td>
<td>High Pre-morbid IQ</td>
</tr>
<tr>
<td>History of Previous Attempts</td>
<td>Poor Pre-morbid Social and Work History</td>
</tr>
<tr>
<td>Preoccupation with Suicide</td>
<td>Loss of Professional Skills</td>
</tr>
</tbody>
</table>

Adapted from Skodlar, Tomori, & Parnas (2008)
Skodlar, Tomori, & Parnas, (2008) completed a powerful study that addressed the subjective experiences of people diagnosed with schizophrenia. After interviewing the participants the researchers found common, not mutually exclusive, categories. All of the participants complained of solitude and inability to participate in human interactions. Many of them (58%, n=11) expressed paralyzing fear of appearing stupid, absence or blockage of thoughts in the presence of others (53%, n=10), lack of how to initiate or continue relationships with others (47%, n=9), failure to understand the rules of interpersonal interactions (42%, n=8), and preoccupation with their physical and overall appearance (42%, n=8). Some participants relayed feelings of great despair and finding relief in planning to commit suicide. (Skodlar, et al, 2008) A second category consisted of feelings of inferiority expressed by the participants. Fifty-eight percent reported feelings of inadequacy, guilt, shame, low self-esteem and saw others as successful, easygoing, and having social interactions. One 32-year-old male said, “I was generally dissatisfied with my life. I felt abandoned. I was analyzing what I did wrong, and how I should do things differently not to end up like this. It seemed like I was too smart for school but too stupid for life.” Another category was the rarity of suicidal intentions at the zenith of psychosis. The majority (74%, n=14) of the participants denied suicidal ideations while experiencing acute psychotic episodes. They explained that during psychotic episodes they were so involved with dealing with or solving the new ideas and situations they were starting to experience. Skodlar, et al (2008) also found a general casualness when talking about suicide and death as displayed by one 29-year-old
patient’s response, “I was always asking myself why I should commit suicide, but I never found a reason for it. So I was saying to myself, ‘you can always do it tomorrow.’” He smiled and added, “You know, suicide is not in line with my life philosophy, though I have always admired seppuku, the noble ritual of samurais, stabbing oneself in the abdomen in order to cleanse one’s dignity.” A protective category was also reported. Participants most commonly reported that they would not commit suicide because of relationships to significant others. (Skodlar, et al, 2008)

Comorbid depression appears to be a significant risk factor for patients with schizophrenia to commit suicide. Hopelessness has been accepted as a significant risk factor for suicide, and this risk factor has been found to be present in patients with schizophrenia. (Hawton, Sutton, Sinclair, & Deeks, 2005) Researchers Montross et al., (2008) hypothesized that current suicidal ideation would have increased levels of depression, negative and positive psychopathology, concomitant medical illnesses, and hopelessness. They completed a randomized, double-blind, placebo-controlled study utilizing the Beck Scale for Suicidal scale to measure the intensity of suicidal ideation, the Hamilton Depression Rating Scale (HAM-D 17) to assess severity of depression, the Positive and Negative Syndromes Scale (PANSS) to measure clinical psychopathology and schizophrenic symptoms, and the Clinical Global Impression Scale (CGIS) to measure illness severity. Results showed that 22% of the participants felt that life was not worth living and 24% had mild suicidality. Patients reported the following: “I have frequent thoughts about killing myself”; “I have held back telling people about wanting
to kill myself”; “I have attempted to hide, conceal, or lie about wanting to commit suicide”; and 2 people said, “I have almost finished or completed my preparations for committing suicide.” Almost half of the participants had admitted to attempting suicide in the past. Patients who had attempted suicide in the past had higher HAM-D 17 scores and higher PANSS General Psychopathology subscale scores. (Montross et al., 2008)

Hopelessness and depression were higher among participants with active suicidal ideation. Overall, Montross et al., (2008) found that past suicide attempts and hopelessness were more predictive of suicidal ideation than depression and psychopathology. Therefore, it is imperative that nurses assess hopelessness in order to determine risk of suicide in patients with schizophrenia.

**Personality Disorders**

It is well accepted that personality disorders are associated with increased suicidal risk, and the majority of research focuses on the cluster B personality disorders, which include borderline, antisocial, narcissistic and histrionic personality disorders. The literature pays specific attention to borderline personality disorder. There is a paucity of evidence suggesting a significant association between cluster A and C personality disorders. Psychiatric providers are presented with a challenging task when treating patients with personality disorders, especially when differentiating between low and high-risk patients.

Borderline personality disorder is characterized by a pervasive pattern of unstable interpersonal relationships, unstable self-image, unstable affects, and poor impulse
control, beginning by early adulthood. One of the criteria for this disorder is recurrent
suicidal behavior, gestures, or threats, or self-mutilating behavior. (American Psychiatric
Association, 2000) In psychiatric patients it is estimated that 30%-60% of patients have a
comorbid diagnosis of borderline personality disorder. (Hahn, Albers, & Reist, 2008)

Soloff et al. (2005) used the Medical Lethality Scale to separate high lethality
suicide attempts, such as overdose with greater than 50 pills or a smaller amount of
highly lethal pills, from low lethality attempts, such as cutting oneself or overdose with
11-50 pills. The following risk factors were associated with high lethality risk: low
socioeconomic status, co-morbidity with antisocial personality disorder, extensive
treatment history, and a high score on the suicide intent scale. Zaheer, Links, & Liu
(2008) partially replicated Saloff et al’s (2005) research and found the following: Suicidal
behaviors in patients with borderline personality disorder on average begin at age 15.8
years and only 1.67% of suicidal acts were carefully planned, suggesting a high level of
impulsivity. Of the suicidal behaviors reported only 12% had a clear expectation of a
fatal outcome. Attempts considered to be of high lethality were made by patients who
were significantly older and had children.

attempters with and without borderline personality disorder. They found that individuals
with borderline personality disorder were significantly more depressed and more
hopeless. Those with borderline personality disorder were also more likely to have more
comorbid Axis I diagnoses, specifically Bipolar I Disorder and Post Traumatic Stress
Disorder (PTSD), and lower Global Assessment of Functioning (GAF) scores. In addition, patients with borderline personality disorder were more likely to have suffered childhood physical and sexual abuse. Berk, Jeglic, Brown, Henriques, & Beck (2007) also found differences in social problem solving between recent suicide attempters with and without borderline personality disorder. Those with borderline personality disorder scored significantly higher on Negative Problem Orientation and were more likely to use impulsive and avoidant problem solving styles.

Substance Abuse

People diagnosed with mental illnesses have a greater likelihood of having a comorbid substance abuse disorder than the general population. There is also a strong relationship between addiction and suicide. (Ries, Yuodelis-Flores, Comtois, Roy-Byrne, & Russo, 2008) Alcohol dependence is an especially strong predictor of suicide. (Ries, Yuodelis-Flores, Comtois, Roy-Byrne, & Russo, 2008) Furthermore, studies have shown that the lifetime risk of completed suicide for those with substance use (alcohol and/or drug) disorders (7%) was more frequent than for mood disorders (6%) or schizophrenia (4%). (Inskip, Harris, & Barraclough, 1998)

Physical Illness

In addition to mental illness, chronic physical illness is also associated with high rates of suicide ideation and completed suicide. Chronic illness and severe pain are significant stressors; therefore it is not unreasonable that they can lead to suicide as supported by the stress-vulnerability mode. It is also not uncommon that mental illness
and chronic physical illness co-occur, which causes even greater stress to vulnerable individuals. Research has shown that chronically ill medical patients have higher levels of anxiety, depression, and substance abuse disorders, which are all factors that increase suicide risk. A severe medical illness forces a person to confront his/her own mortality and subsequently increases suicidal ideation. (Druss, 2000) Medical illnesses can lead to chronic and acute disability. Pulmonary illness, such as asthma poses the risk of potentially life threatening exacerbations with symptoms that are similar to those seen in panic disorder. Cancer presents the risk of severe pain, disfigurement and risk of death. Understanding the association between medical illness and suicidal behavior is particularly important for emergency nurses that are accustomed to treating people with life-threatening medical illnesses.

Druss (2000) administered the depression module of the Diagnostic Interview Schedule to 7,589 individuals between the ages of 17 and 39 years. The most commonly cited medical illnesses were as follows: diabetes, thyroid disease, cancer, asthma, and arthritis. A total of 16.3% of respondents reported a lifetime history of suicidal ideation and 5.5% had made a suicide attempt at some point in their lives. In addition, 8.0% of participants met DSM IV-TR criteria for depression and 9.6% reported drinking more than 5 alcoholic beverages per day. Comorbid depression was associated with an increased lifetime history of suicidal ideation and suicidal attempts. The medical illnesses associated with the greatest increase in suicidal behavior were asthma, bronchitis, and cancer.
Medical illness can also masquerade as mental illness, and it can be difficult to
distinguish between primary mental illness and mental disorders due to a general medical
condition. A few of the more common medical illnesses associated with mood symptoms
are strokes, multiple sclerosis, Parkinson’s, HIV, Huntington’s disease and pancreatic
cancer. Interestingly, 40% of patients with pancreatic cancer report depressive symptoms
before diagnosis of pancreatic cancer. Fifty-percent of post-stroke patients also complain
of depression and a person with a diagnosis of multiple sclerosis might present with
secondary mania. (Sadock & Sadock, 2007)

Summary

Mental illnesses that are particularly concerning for an increased risk for suicide
are mood disorders, schizophrenia, personality disorders, and substance abuse disorders.
Patients with bipolar I disorder are at the highest risk for suicide, especially when
experiencing mixed states. (Dubovsky & Dubovsky, 2008) In patients with
schizophrenia, suicide is the leading cause of premature death with a lifetime risk for
completed suicide between 9% and 13%. (Caldwell & Gottesman II, 1990) Personality
disorders in general place a patient at higher risk for suicide, and borderline personality
disorder in particular is characterized by chronic suicidality. Unfortunately, people with
mental illness are more likely than the general population to use substances, and there is a
strong association between addiction and suicide. (Ries, Yuodelis-Flores, Comtois, Roy-
Byrne, & Russo, 2008) Lastly, chronic and painful physical illnesses often cause patients
to confront their own mortality, which can lead to suicidal behavior.
CHAPTER 3

Introduction

The Community Mental Health Act of 1963, led to deinstitutionalization, and as many as 92% of people who would have lived in psychiatric institutions were released to live in the community with the plan that mentally ill individuals would be fully supported with outpatient services. Unfortunately, poor planning led to a lack of psychiatric resources and inconsistent medication management and outpatient services. (Lauer & Brownstein, 2008) This has led to numerous and repeated psychiatric hospitalizations for mentally ill people, as well as a great influx of people experiencing psychiatric crises into emergency departments. This prompts further investigation into what type of education emergency department nurses need to better care for mentally ill patients.

This chapter will discuss attitudes held by the general population and emergency nurses towards people with suicidal behavior and mental illness. Literature has been reviewed and both quantitative and qualitative data will be presented to illuminate the significance of attitudes on suicidal behavior. The subjective experiences of patients who have engaged in suicidal behavior will also be discussed. Finally, the literature pertaining to assessment of suicidal patients was reviewed and will be presented along with implications for suicide assessment and management education.

Attitudes Towards Suicide

Suicide can cause uneasiness in people and many people prefer to avoid the topic, therefore it is likely that myths related to suicide have been developed. It is possible that
these myths are a protective mechanism that function to reduce anxiety by avoiding the topic of suicide. (Hjelmeland & Knizek, 2004) Anxiety and untrue beliefs regarding suicide are especially problematic for medical professionals who will undoubtedly come into contact with patients who are contemplating suicide or who have attempted suicide.

Hjelmeland and Knizek (2004) completed a study that investigated what myths about suicide are common among the general public. They asked about causes of suicide, whether suicide can be prevented, and whether participants had personal experience with suicide. The researchers used The Attitudes Towards Suicide questionnaire (ATTS), which consists of 37 questions regarding attitudes towards suicide. Participants were also asked questions about their own life, death wishes, and suicidality. Most questions were scored on a 5-point Likert scale and there were two open-ended questions. The four Likert scale items presented in the study were: 1) There is a risk to evoke suicidal thoughts in a person’s mind if you ask about suicide, 2) People who talk about suicide do not commit suicide, 3) Suicide happens without previous warning, and, 4) Once a person has made up his/her mind about committing suicide no one can stop him/her. The two open-ended questions were: 1) What do you think is the most important cause of suicide? 2) What do you think should be done to prevent suicide?

The results yielded useful information on the relationship between variables, but the relatively small response rate did not provide information about the total prevalence of myths in the general population. There were some significant correlations between belief in suicide myths and experience with suicidal behavior. A negative correlation was
seen between a person’s experience with suicide and the statement, “People who talk about suicide do not commit suicide”. People with one or more suicide attempts in family or friends were more likely to disagree with this statement. There was also a negative correlation between the statement, “Suicide happens without previous warning”, but in this instance people who had experience with one or more suicide attempts in friends, as well as those with a personal suicide attempt disagreed with this statement. Two statements showed positive correlations. Participants that had experienced a completed suicide in their family were more likely to agree with the statement, “There is a risk to evoke suicidal thoughts in a person’s mind if you ask about it”. Lastly, participants that had experienced a completed suicide in a family member or friend were more likely to agree with the statement, “Once a person has made up his/her mind about suicide, no one can stop him/her”.

Study participants were also asked, “What do you think is the most important cause of suicide?” Their answers were separated into three categories: 1) Intrapersonal, which is defined as existing within oneself or mind 2) Interpersonal, which is defined as relationships between people and 3) Extra-personal. The majority of respondents cited psychological intrapersonal reasons as the most significant cause of suicide, and this included loneliness, hopelessness, powerlessness, bad self-image, jealousy, distrust, anxiety, inability to talk about problems, anger, and personal crisis. A small number of participants cited more judgmental forms of psychological intrapersonal causes for suicide, such as egoism, weakness, cowardice, self-pity, a need of being noticed, and bad
judgment. Finally, the participants suggested mental/physical illness, existential factors, and sexual orientation as significant intrapersonal causes of suicide.

The second most common category cited for cause of suicide was interpersonal, and within this category the majority of participants cited reactive causes for suicide. This included problems, conflicts, losses, personal history, social network, and not being heard. Altruism was suggested by a small number of participants who believed some people commit suicide so that they will not become a burden to loved ones. An even smaller number of participants cited suicide as a way of manipulating the environment (regulative).

The last category listed as a cause of suicide was extra-personal causes. This category includes the idea that societal demands are most often too high but may also be too low. More specifically, the study participants mentioned financial stressors and employment problems as significant causes of suicide.

The study by Hjelmeland and Knizek (2004) provided useful insight into the general population’s beliefs regarding suicide prevention. It was found that 83% of the participants agreed to some degree that suicide can be prevented and 62% believed that it should be prevented in all cases. A great majority of the participants suggested that changes in society be made so that suicide is not a taboo subject, which would allow more open communication regarding the topic. They also advocated for better accessibility to mental health services and competent providers. Lastly, many participants believed that people should take greater responsibility for the welfare of each other.
Brunero, Smith, Bates, & Fairbrother (2008) studied the attitudes that health professionals hold toward suicide prevention initiatives and how these initiatives might influence their suicide risk assessment and management skills. The study was performed in Australia where deaths from suicide outnumber the deaths from motor vehicle accidents. It was noted that a mental health professional is the most appropriate and competent person to perform a suicide risk assessment, however general health professionals were being placed in situations where they were responsible for the assessment. Review of the literature demonstrated that attitudes toward suicidal patients were more positive in mental health professionals than in general and emergency medicine professionals.

Brunero et al’s (2008) study examined factors associated with attitudes towards suicide prevention among non-mental health professionals with the purpose of educating staff. The following questions were proposed: 1) Do staff who have attended suicide prevention education have more positive attitudes? 2) Do staff with professional experience in working with suicidal patients have more positive attitudes? 3) Does personal experience with suicide result in more positive Attitudes to Suicide Prevention Scale (ATSP) results?

A problem-based learning framework was used to develop an educational program that consisted of a one-hour face-to-face group session with follow-up self-directed study material. Groups were formed that ranged in size from six to 15 people and each group session was started by asking the participants to think of a clinical case in
which the patient became suicidal. Throughout the session the participants’ attitudes about the case were challenged. Information on suicide rates and risk factors were discussed and management of suicidal patients was interwoven into the session. Following the session the participants were provided with online suicide risk assessment and management training.

Results showed that people who had received suicide prevention education in the past, or those who had personal exposure to suicide held more positive attitudes towards suicidal patients. Having only professional experience with suicide did not show a statistically significant relationship to attitudes on the ATSP scale. Longer time spent in a non-mental health specialty positively correlated with agreement to the following negative statements: “I resent being asked to do more about suicide.” “Suicide prevention is not my responsibility.” “If people are serious about committing suicide, they don’t tell anyone.” “I don’t feel comfortable assessing someone for suicide risk.” “There is no way of knowing who is going to commit suicide.” (Brunero, Smith, Bates, & Fairbrother, 2008) In contrast, prior personal experience with suicide or attempted suicide correlated with more positive attitudes and agreement to the following statement: “People have the right to take their own lives.” Sadly, when compared to other health care professionals nurses held somewhat more negative attitudes towards suicidal patients.

The study found, as other studies have, that targeted training does have an effect on improving attitudes, skills and knowledge. This study did not find significant data to support this idea. Finally, personal experience with suicide was shown in the Brunero,
Smith, Bates, & Fairbrother (2008) study to be related to more positive attitudes. Treloar & Lewis (2008) assessed the impact of attending targeted clinical education on borderline personality disorder on the attitudes of health clinicians towards working with deliberate self-harm behaviors. Health professionals often express negative and derogatory attitudes towards patients with borderline personality disorder that self-harm. In fact, studies show that across many countries health professionals often avoid contact with patients with borderline personality disorder or fail to engage in any meaningful dialogue with these patients. (Treloar & Lewis, 2008) Patients with borderline personality disorder report being left to wait in emergency departments for treatment of self-inflicted harm.

Treloar & Lewis (2008) developed an education program for health care professionals to increase knowledge relating to prevalence rates of borderline personality disorder, definitions and rates of self-harm and suicide and therapeutic responses to borderline personality disorder. The results showed that female clinicians demonstrated significantly improved attitudes after attending the educational program. The change in attitude was not significant for male clinicians. Remodeling attitudes of health care professionals towards borderline personality patients that self-harm is important because research shows that unsympathetic responses tend to escalate behavioral disturbances and negatively effect a patient’s engagement in treatment. (Hemmings, 1999)

Experiences of Patients Who Self-Harm

Admission to emergency departments for suicidal behavior is often a traumatic
experience for patients. This is important for emergency nurses to understand since the emergency department is often the place where patients first seek help; therefore nurses are in a prime position to help patients and their families. Unfortunately, studies have shown that the care of patients with suicidal behaviors in emergency departments is not always appropriate. For example, there is significant misuse and overuse of seclusion and restraint. (Allen, Carpenter, Sheets, Miccio, & Ross, 2003) In order to decrease the use of restraints it is suggested that emergency staff try other methods of de-escalation first. These methods include decreasing environmental stimuli by dimming lights and decreasing noise, allowing the patient to stand or sit in a position of his/her choice, avoid overwhelming the patient with multiple staff and security, and ask the patient what they need to calm down.

Allen et al. (2003) completed a study that used four different focus groups consisting mental health professionals and patients that had at least one emergency service experience that included medication, seclusion, and/or restraint. The focus groups included patients from four different geographic areas that had been hospitalized in a variety of states and in three different countries. Half of the participants were admitted to an emergency department voluntarily and half were involuntarily. Initially, the participants were asked why they chose to participate in the study and the overwhelming response was that they appreciated that someone was willing to listen. The participants were then asked to complete a survey about their past experiences as suicidal patients in emergency departments. Lastly, the participants engaged in an exercise to develop
recommendations for improving emergency services care.

Results of the Allen et al. (2003) study were eye-opening and disheartening. The most common reasons were “feeling out of control” (68%), “relationship problems with family, friend or spouse” (58%), and “being very afraid” (54%). The majority of participants agreed that they received poor treatment from emergency staff and commented that staff was disrespectful. They also stated that staff did not see them in a timely manner, listen to them, spend enough time with them, adequately address their problems, or explain proposed treatments prior to asking for consent. Fifty-three percent of the participants did not believe that staff was equipped to deal with their specific religious and cultural needs. Less than half of the participants experienced an act of kindness from staff.

Improving the care that suicidal patients receive in the emergency department is vitally important. Emergency nurses can do this by listening to the patient and his/her version of the events leading up to hospitalization. Nurses should make an effort to spend enough time with the patient to address the patient’s questions and to explain the proposed treatments. It is also important to ask the patient what type of treatment s/he wants and how his/her religious or cultural needs can best be met.

Participants in the Allen et al. (2003) and a Cerel, Currier, & Conwell (2006) study were also asked to respond to open-ended questions. First, participants wrote about their experiences related to the importance of being treated as a human being and retaining one’s dignity. Positive experiences included, the provision of comfort measures,
such as staff giving patients blankets, pillows, food, and allowing patients to remain in their own clothes. Participants also reported negative experiences, such as being immediately disrobed and given an injection. The importance of staff professionalism was also discussed. One participant stated, “Because I tried to kill myself by overdosing with alcohol and medications, I was treated meanly and the staff was cold. The police were laughing and joking with each other about what a loser I was”. Another participant in the Cerel, Currier, & Conwell (2006) study said, “The nurse asked me what kind of mother could I be, doing this to my children?” Participants agreed that having staff listen to them is of utmost importance and gave the following positive and negative examples. Some felt that their suicide attempt was not taken seriously. “After I had taken pills, all they did was send me home with a sheet that said I needed to drink plenty of fluids and rest”. (Cerel, Currier, & Conwell, 2006) Fortunately, some participants expressed good experiences with staff. “The nurse practitioner was very kind, soft-spoken, and receptive to my mood and feelings of being overwhelmed. She soothed my senses.” (Allen, Carpenter, Sheets, Miccio, & Ross, 2003) Another topic that participants commented on was the importance of being asked what they needed or wanted. They agreed that it was meaningful when staff asked if they need anything in a sincere and compassionate manner. However, many participants recalled negative experiences of being left alone and ignored. They said that the housekeeping staff and techs were more compassionate than the nurses and doctors.

The use of medications and restraints were also discussed in the Allen et al.
(2003) study. Half of the participants had not been asked about what medications had been helpful in the past, 35% felt that they had been forced to take medications and 61% stated that the medications produced undesirable side effects. Sixty-three percent of the participants reported that they had been placed in restraints and 67% of those that were placed in restraints reported that the staff had not tried anything else first. Most of those participants that were in restraints felt that staff made a poor decision to use restraints (69%), felt they were in restraints too long (68%), and that no one listened to them or respond to their requests (77%). Importantly, 54% of those placed in restraints report unwillingness to seek psychiatric care in the future.

In completion of the Allen et al. (2003) study participants were asked about medication preferences and what staff behaviors are most important. Overwhelmingly, oral medications were preferred to injections and anti-anxiety agents were preferred to antipsychotic agents. The most important and commonly cited staff behaviors were: 1) Having the staff listen to me, my story, and my version of events. 2) Being asked about what treatment I want. 3) Trying to help me calm down before resorting to forced treatment. 4) Being asked about what treatments were helpful and not helpful to me in the past.

Assessment of Suicidal Patients

Assessment of suicidal patients in the emergency department begins with triage. In Phoenix, Arizona there are only two specialized psychiatric emergency departments, therefore general emergency departments are usually the first place suicidal patients
present for help. Emergency department staff often feels that triaging suicidal patients is challenging for a variety of reasons. Staff may not feel confident in their abilities to accurately triage suicidal patients and they might lack skill and knowledge related to treating suicidal patients. Unfortunately, simply asking a patient whether or not s/he is suicidal does not confirm accurate information. During busy times in the emergency department it is vital that the triage nurse is able to safely determine if a suicidal patient can wait unsupervised or requires one-to-one supervision to ensure patient safety. The effective triage of suicidal patients relies heavily on the attitude of the triage nurse; therefore training and education are indicated for emergency department triage staff.

The purpose of the triage assessment is to rapidly identify those individuals with an urgent, life threatening condition; to determine the most appropriate treatment area for a particular patient; and to provide a structure for ongoing re-assessment of those patients who need to wait. (Clarke, Brown, & Giles-Smith, 2008) Patients might present to the emergency department with suicidal ideations or self-harm injuries of low to high lethality. Triage nurses regularly express frustration with patients who self-harm on a chronic basis, however it is important to not trivialize self-harming behavior as nothing more than attention-seeking behaviors. Research has shown that approximately four percent of patients who chronically self-harm will eventually die by suicide. (Clarke, Brown& Giles-Smith, 2008) It is also significant to note that the risk of death by suicide within one year of self-harming behavior is 66 times greater than that of the general population. (Hawton, Zahl, & Weatherall, 2003)
Suicidal assessment can be simple and straightforward or vague and more complex. Patients that present to the emergency department and complain of suicidal ideation are rather straightforward and the next step is to ask the patient if s/he has a plan, and if yes, ask about the details of the plan. The triage nurse must be mindful to assess the expected outcome of the plan and not necessarily the lethality of the plan. If the patient plans to consume a large amount of a non-lethal substance with the belief that there will be a fatal outcome the patient should be considered high risk. (Clarke, Brown, & Giles-Smith, 2008) Some patients will undoubtedly present to the emergency department with vague and non-specific symptoms that might still be at high risk for suicide. In this case the triage nurse should ask about current stressors, anxiety or fear, hopelessness, and suicidal thoughts. Clarke, Brown, & Giles-Smith (2008) suggests the following questions to facilitate communication about suicide intention and risk: 1) Are things so bad you sometimes wish you did not wake up in the morning? 2) Do you wish you were dead? 3) Have you thought about harming yourself? 4) Have you made plans/preparations? 5) Have you been close to doing something? 6) Have you done something? The last question may in fact reveal an actual attempt that requires urgent medical attention.

Patients who leave without being seen are concerning to emergency departments and especially distressing when the patient had presented to the emergency department with suicidal ideations. A person is considered “left without being seen” when s/he checks in with the triage nurse and leaves before triage or leaves after being triaged by
the nurse but leaves before a medical screening is completed by a licensed provider, such as a medical doctor (MD), doctor of osteopathy (DO), nurse practitioner (NP), or physician’s assistant (PA). If there is a concern that a patient might be a flight risk the triage nurse must ensure the safety of the patient and provide the appropriate safety measures, such as assigning a security officer, staff member, or patient family member to stay with the patient at all times. Most importantly, the triage nurse needs to remember that suicidal ideation is an urgent matter that needs to be immediately addressed.

The guarded suicidal patient poses a special challenge to emergency department staff. These patients might be vague when expressing their desire to commit suicide and will require astute assessment by nursing and medical staff. Emergency department nurses need to be educated on characteristics of the guarded suicidal emergency department patient, especially since 14%-18% of suicide victims are seen by non-psychiatric providers in the weeks or months preceding the suicide. (Giordano & Stichler, 2009) Isometsa et al. (1995) also found that most patients who completed suicide did not relay their suicidal intent during their final interaction with medical staff. It is important that nurses understand that guarded suicidal patients are not always consciously evasive. Many of them are scared, embarrassed, in denial, minimizing, and defensive. (Simon, 2008)

Observation of a patient’s non-verbal behavior becomes important when assessing patients who might be at risk for suicide but fail to openly communicate. Some non-verbal cues to watch for are psychic anxiety, decreased concentration, insomnia,
agitation, and irritability. (Simon, 2008) Specifically, agitation indicates a high risk for suicide. Fawcett (2007) describes that agitation can “frequently be estimated by observing the patient fidgeting, wringing hands, moving, picking while seated, or at more severe levels by pacing, moaning or pounding doors and walls all the way to assaultive behavior.” Family and friends of the patient can also be a valuable source of information to the assessing nurse. The patient’s significant others can often provide historical data, such as previous cues that were present the last time the patient was contemplating suicide. For example, a patient might begin to “clang”, or rhyme, when his/her illness worsens. Data from sources other than the patient is especially important in recognizing patterns that indicate suicidal ideation in individual patients that have a suicidal attempt history. However, despite best efforts at performing behavioral risk assessments it may not be possible to identify the level of suicide risk in a guarded patient. Nonetheless, it remains a valuable tool in assessing patients in time-limited settings. In addition, sudden, unexplained improvement in a patient at high risk for suicide might indicate a sense of peace stemming from a final decision to complete suicide, which makes it important to include systematic suicide assessment with behavioral assessment. (Simon, 2008)

Giordano and Stichler (2008) developed an educational program to enhance nurses’ knowledge related to identifying emergency department patients at high risk for suicide in the triage area. The program was guided by the Disciplined Clinical Inquiry conceptual framework, which addresses “ways of knowing”, such as aesthetic, intuitive, personal, and ethical. Suicide risk was assessed using the modified SAD PERSONS
scale. This scale uses the following 10 part mnemonic to assess for suicidality and each “yes” answer receives one point.

S) Sex: Men are more likely to use more lethal suicide methods than women. (Sadock & Sadock, 2007)

A) Age: Older adolescents and people older than 55 are at increased risk for suicide. (Sadock & Sadock, 2007)

D) Depression: There is a high correlation between suicide and depression and approximately 15% of depressed individuals commit suicide. (Dubovsky & Dubovsky, 2008)

P) Prior History: A previously unsuccessful suicide attempt is one of the best single predictors of future suicide. (Sadock & Sadock, 2007)

E) Ethanol Abuse: There is a high correlation between substance abuse and suicide. (Ries, Yuodelis-Flores, Comtois, Roy-Byrne, & Russo, 2008)

R) Rational Thinking Loss: Delusions, hallucinations, and inability to differentiate reality from unreality increases the risk of suicide.

S) Support System Loss: Isolation and impaired social relationships increase the risk for self-harm.

O) Organized Plan: A specific plan is a significant risk factor for suicide. (Clarke, Brown, & Giles-Smith, 2008)

N) No Significant Other.

S) Sickness: Chronic and painful illnesses increase the risk for suicide.
Table 3.1. Scoring for SAD PERSONS Scale

<table>
<thead>
<tr>
<th>Score</th>
<th>Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-2</td>
<td>Very low risk: encourage counseling and allow to go home</td>
</tr>
<tr>
<td>3-4</td>
<td>Low risk: encourage close follow-up and counseling</td>
</tr>
<tr>
<td>5-6</td>
<td>Moderate risk: consider hospitalization involuntary or voluntary,</td>
</tr>
<tr>
<td></td>
<td>depending on your level of assurance patient will return for follow-up</td>
</tr>
<tr>
<td>7-10</td>
<td>High risk: definitely hospitalize involuntarily or voluntarily</td>
</tr>
</tbody>
</table>

Table developed with information obtained from Juhnke (1994)

In the Giordano and Stichler (2008) education program a variety of modules were used to enhance knowledge about suicidal risk and to improve nurse assessment skills. It was mandatory for all emergency department nurses to attend. A Likert-scale with 10-items and five categories was used for the pre and post-test. Higher scores indicated a higher level of knowledge about suicide risk factors and interventions. Statistical analysis of the data from the pre and post-test was used to measure program efficacy. Mean scores for the posttest were higher than mean scores for the pretest (M= 45.29 vs. M= 39.73). These findings indicated that the educational module was successful in enhancing nurse knowledge about suicide risk factors and treatment options.

Chan, Chien, & Tso (2008) performed a study to evaluate the effect of an education program on nurses’ knowledge, attitude and competence on suicide prevention and management for patients with suicide attempt or ideation and their family members. Programs that address not only competence in assessing suicidal patients, but also nurses’
attitudes are vital because attitudes, in addition to knowledge are important in the prevention of suicide. (Repper, 1999) Unfortunately, patients who attempt suicide are likely to receive criticism from nursing staff. Chan, Chien, & Tso’s (2008) study was conducted in two Hong Kong hospitals and measured participants’ changes in knowledge, attitude and perceived competency for the quantitative design and used focus groups for the qualitative portion.

Prior to meeting with focus groups the participating nurses completed and 18-hour education program. This program was developed because there was an increase in the number of people that had attempted suicide admitted to the general hospital. Nurses voiced concerns that they did not feel adequately prepared to work with suicidal patients. In fact, some nurses admitted to avoiding suicidal patients. The program was guided by the Stress Vulnerability Model, which explains how suicidal ideation develops into suicide attempt. Teaching methods included reflective discussion, lectures, role-play, case studies, and self-directed learning.

Results of the Chan, Chien and Tso (2008) study showed that overall nurses were satisfied with the educational program. Feedback received from nurses in focus groups showed that the program increased nurses’ knowledge on suicidal risk factors and increased awareness of their responsibility towards preventing suicide. The nurses also reported increased understanding that patients and families need psychological support, practical help, information, and communication following a suicide attempt. Furthermore, outcome evaluation showed further that the program facilitated changes in nursing
practice, helped improve nurse self-confidence and improved nurse attitudes towards those who self-harm.
CHAPTER 4
Significance to Nursing Practice and Suggestion for Education

Suicidal behavior has been present for centuries and will continue to be a significant health risk. Since the deinstitutionalization of mental health care in the 1960s, there has been a significant increase in the number of mentally ill individuals desperately in need of mental health services. It is estimated that 30% of the U.S. population meets Diagnostic and Statistical Manual of Mental Disorders criteria for one or more behavioral disorders in any given year, and less than half receive any mental health care. (Druss et al., n. d.) Therefore, it is imperative that nurses are trained to work with mentally ill people. The high prevalence of disorder and low accessibility for treatment makes emergency departments likely settings for mental health care. Nurses need to be educated on competent assessment of suicidal patients to meet a newly approved JCAHO safety goal that requires documented suicide-risk assessments for patients in acute care hospitals.

Research has shown that mental health professionals are the ideal providers of emergency psychiatric care. Currently, many emergency departments have implemented an array of models to improve the treatment of psychiatric patients, and psychiatric mental health nurse practitioners are well-prepared to assess, diagnose, and treat psychiatric emergencies in general emergency departments. Consultation mental health services are commonly used in Phoenix emergency departments, however the assessments are performed by master level counselors that are not able to initiate
pharmaceutical treatment while the patient waits in the emergency department for an inpatient psychiatric bed. Another successful program has been the initiation of psychiatric mental health nurse practitioner outpatient clinics associated with the emergency department. This provides a place for follow-up to underserved and vulnerable patients that do not require immediate hospitalization. Unfortunately, these services are not readily available in most emergency departments; therefore educating non-mental health nurses on the treatment of suicidal patients is necessary.

This project shows, through the compilation of data, that emergency department nurses are not trained to adequately assess and manage suicidal patients in the emergency setting. This is concerning since poor management of these patients cannot only lead to completed suicide but also to litigation against hospitals when care is mismanaged. Nurses are at the forefront of treating suicidal patients but generally do not feel confident in their abilities to accurately triage suicidal patients. Emergency nurses are trained to quickly assess and stabilize medically ill patients but often fail to provide psychosocial support to the patient and his/her significant others.

The information in this project has been used to develop, implement, and evaluate a formal training program that focuses on improving the attitudes of emergency department nurses towards patients who self-harm and to improve the suicide assessment skills of emergency department nurses. This educational program can be implemented in any emergency department. The educational program will be delivered via an online PowerPoint presentation that all ED nurses are required to complete. PowerPoint
presentation is a popular method to relay information using written information with verbal presentation and the possibility for pictures and video clips. Knowledge can be assessed with a pre and post-test. (See Appendix)

The program will focus on educating nurses on the various types of suicide behavior, the relationship between mental and physical illness with suicide attempts, suicide assessment, and the experience of patients who self-harm. In addition, the program will enhance the participating nurses’ awareness of suicide risk factors, resources for intervention and treatment, and potential adverse patient and hospital outcomes when suicide risk is not properly identified.

Conclusion

Mental health is one of the ten leading Healthy People 2010 initiatives that are being used to measure the health of the nation and mental illness is correlated highly with suicide, which is the cause of more deaths annually than HIV or homicides. The stress-vulnerability model provides a framework from which one can understand the etiology of mental illness. Development of mental illness stems from both biological vulnerability and stressors that can precipitate or exacerbate symptoms of mental illness. The greatest emergency in psychiatry is suicide, and suicidal patients seek health care in a variety of arenas, therefore non-psychiatric health providers will likely encounter patients that have attempted suicide or contemplating suicide. Emergency departments commonly provide acute management of patients with a variety of suicide behaviors; therefore this project was developed to address the need for more suicide education for emergency department
nurses. A synopsis of the background, risk factors and etiology of suicidal behavior was included to introduce the reader to the significance of suicide. An in depth literature review of major suicide risk factors was completed to provide an all-encompassing description of the significant components that might lead to behaviors that fall along the suicide continuum. Research has shown that an increase in nursing knowledge on suicidal risk factors can increase nurses’ sense of responsibility to care for patients exhibiting suicidal behaviors.

This project also addressed attitudes towards suicidal patients and experiences of patients who have self-harmed, followed by evidenced-based information on competent assessment of suicidal patients. Common beliefs held by the general population and nurses towards suicidal patients suggested that suicide is a complicated subject that generates contradictory emotions in people. There appears to be confusion as to whether suicide can be predicted and/or prevented. Fortunately, research has shown that education on suicide can improve the attitudes of people towards suicidal patients. This is of significant importance for emergency department nurses who are usually the first health care providers to assess suicidal patients. The literature showed that staff might not feel confident in their ability to accurately assess suicidal patients, therefore suggestions were provided to aid in the improvement of suicide assessment skills.

The information in this project provides synthesized data about suicidal behavior in emergency departments and has addressed gaps in nursing knowledge. Suicidal behavior will continue to be treated in medical emergency departments and educational
programs must be developed to ensure that emergency department nurses are able to competently and comfortably treat suicidal patients. The data in this paper has been used to create an educational program using PowerPoint presentation that can be presented to emergency department nurses, however there are many other creative and succinct ways to deliver this information in an educational format. The scope of this project precluded actual implementation and evaluation of the educational program.
APPENDIX: OUTLINE OF EDUCATIONAL POWERPOINT
APPENDIX

Outline of Educational PowerPoint

Caring for Suicidal Patients

Why You Should to Care

• Specialized emergency psychiatric services are not readily available
• Lack of inpatient psychiatric beds leads to boarding of psychiatric patients in the ED
• Failure to identify a person at risk for suicide places you and the hospital at risk for litigation
• 14-18% of suicide victims are seen by non-psychiatric providers preceding suicide
• JCAHO has mandated that a documented suicide-risk assessment be performed on patients in acute care settings

Is Mental Illness Really a Problem?

• Mental illness is the 2nd leading cause of disease burden in the US
• 28-30% of Americans have a mental or substance abuse disorder
• Suicide is among the top 12 causes of death in the US
• Suicide is the 3rd leading cause of death in people ages 15-24 (Institute of Medicine, 2009)
• White males over 85 are at the highest risk
• For every 1 suicide there is an estimated 800,000 attempts (Giordano & Stichler, 2009)

How Does This Affect Me in the ED?

• The ED serves as a primary point of care for people at high risk for suicide
• At least 5.4% of ED visits are mental health related
• Suicide can be prevented with competent assessment and treatment
• The care given to a suicidal patient can have a long-standing impact (Larkin, Smith & Beautrais, 2008)

What is Considered Suicidal?

• Suicidal Ideation: thoughts of harming or killing oneself
• Suicide Attempts: non-fatal, self-inflicted destructive acts with explicit or inferred intent to die
• Suicide: fatal self-inflicted destructive act with explicit or inferred intent to die
• Para-suicidal Behaviors: willful self-inflicting of painful, destructive or injurious acts without the intent to die
(Suicide Prevention, 2009)

What Are the Risk Factors?

- Men are 4 times more successful in completing suicide than women
- Women are 4 times more likely than men to attempt suicide
- Suicide increases during the middle of life and peaks in men after age 45 and in women after age 55
- Older than 75 are at the greatest risk
- Risk is increasing most quickly in age 15-24
- Immigrants are at a greater risk than native born Americans
  (Sadock & Sadock, 2007)

Are There More Risk Factors?

- Married people are less likely to commit suicide
- The following are at increased risk:
  - Higher SES status
  - Sudden fall in SES
  - Physicians, law enforcement agents, dentists, artists, mechanics, lawyers and insurance agents are at increased risk
  - Female nurses!!
  (Kelly & Bunting, 1998)

What Causes Someone to Want to Die?

- Both stress and biology contribute to symptoms of mental illness
- “Biological Vulnerability” refers to people who are born with, or who acquire early in life a predisposition to develop a problem, such as physical and mental illness
- Stress plays a significant role in the development of psychiatric symptoms
  - In a genetically predisposed individual stress can make symptoms worse or may trigger the onset of symptoms
  (Stress-Vulnerability, 2009)

How Can the Stress-Vulnerability Model Guide Treatment?

- Chronic and acute stress can worsen suicidal behaviors therefore;
  - Suicide attempts are prevented by using medications to reduce biological vulnerability
  - Stress reduction
  - Increase coping skills to decrease stress
  (Stress-Vulnerability, 2009)

How is a Mood Disorder Related to Suicide Risk?

- In the general population about 5% of people with depression commit suicide
- In the clinical setting, approximately 15% of people with depression commit suicide
- More than 1/3 of patients receiving care in an ED for a suicide attempt have a mood
disorder (Dubovsky & Dubovsky, 2008)

• **Hopelessness**, a criterion for major depressive disorder is a consistent predictor of suicide (Beck & Weishaar, 1990)

How is a Mood Disorder Related to Suicide Risk?

• Risk of suicide is highest in bipolar disorder
• 20%-50% of bipolar patients attempt suicide at least once
• 1% of bipolar patients commit suicide
• Especially high risk in mixed states (depressed and manic)
• Suicidality with high energy and impulsivity
• Suicide attempts are often of **higher lethality** when performed by a person with bipolar d/o
• A family history of suicide doubles the risk
• Stress can increase risk

(Dubovsky & Dubovsky, 2008)

What About Schizophrenia?

• Schizophrenia is characterized by 2 or more of the following:
  – Delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior and negative symptoms
• Onset is usually before age 25 and persists throughout life
• When onset is precipitated by obvious stressors the prognosis is better than with an insidious onset

(Sadock & Sadock, 2007)

How is Schizophrenia Related to Suicide?

• Suicide is the **leading** cause of premature death among people with schizophrenia
• Lifetime risk of suicide is 9-13%
• Attempted suicide rates are between 20% and 40% (Caldwell & Gottesman II, 1990)
  – Indicates a high level of distress
• White, male, younger than 45 and within the first 10 years of illness are more likely to commit suicide (Pinikahana, Happell, & Keks, 2003)
• Co-morbid depression increases a person’s risk for suicide
• Suicide is less common during extreme psychosis

(Skodlar, Tomori & Parnas, 2008)

What Else is Important to Know About Schizophrenia?

• People with schizophrenia complain of solicitude and inability to participate in human interactions
• Paralyzing fear of appearing stupid
• Absence or blockage of thoughts while in the presence of others
• Failure to understand the rules of interpersonal interactions
• Preoccupation with their physical and overall appearance
• Feelings of inadequacy, guilt, shame, low self-esteem, and see others as successful
• Great despair that is relieved with a suicide plan
  (Skodlar, Tomori & Parnas, 2008)

“I was always asking myself why I should commit suicide, but I never found a reason for it. So I was saying to myself, ‘you can always do it tomorrow.’” He smiled and added, “You know, suicide is not in line with my life philosophy, though I have always admired seppuku, the noble ritual of samurais, stabbing oneself in the abdomen in order to cleanse one’s dignity.”
  (Skodlar et al, 2008)

Borderline Personality Disorder and Suicide
• BPD is characterized by a pervasive pattern of unstable interpersonal relationships, unstable self-image, unstable affects, and poor impulse control
• 30-60% of psychiatric patients have a co-morbid diagnosis of BPD (Hahn, Albers & Reist, 2008)
• It is often difficult to differentiate between low and high risk patients
  – Recurrent suicidal behavior, gestures, threats, and/or self-mutilating behaviors
  (Soloff et al, 2006)

Borderline Personality Disorder and Suicide
• Only 1.6% of suicidal acts are carefully planned--HIGHLY IMPULSIVE
• Only 12% of suicidal behaviors have a clear expectation for a fatal outcome
• Health professionals often hold negative and derogatory attitudes towards patients with BPD
  – This is detrimental to the well-being of BPD patients
• Nurses should assess for factors that increase the patient’s risk for high lethality suicide attempts
  – Low SES, extensive treatment history and a high intent score
  (Soloff et al, 2005)

Substance Abuse and Suicide
• People with mental illness have a greater likelihood of having co-morbid substance abuse disorder
• Lifetime risk of suicide is higher in substance abusers than in people with mood disorders and schizophrenia
• Strong relationship between addiction and suicide
  – Especially with alcohol dependence
  (Ries et al, 2008)

Physical Illness and Suicide
• Chronic illness is associated with an increased risk for suicide
• Mental illness and chronic illness often co-occur, with high levels of anxiety and depression

• Associations between medical and mental illness
  – Asthma causes symptoms similar to panic attacks
  – Cancer causes severe pain and the possibility of death leading to anxiety and depression

  (Druss, 2000)

Can Medical Illness Masquerade as a Mental Illness?

• YES
  – 40% of people diagnosed with pancreatic cancer experience depression prior to diagnosis
  – 50% of CVA patients develop depression
  – Multiple sclerosis can cause depression or mania
  – Parkinson’s, HIV and Huntington’s can cause anxiety, depression or psychosis

  (Sadock & Sadock, 2007)

Exposing the Attitudes People Hold Towards Suicidal Patients

• Suicide causes uneasiness in many people
• People prefer to avoid the topic
• 83% of people believe suicide can be prevented
• Only 62% believe suicide should be prevented
• People want to see better accessibility to mental health services and competent mental health providers

  (Hjelmeland & Knizek, 2004)

What Do Health Care Workers Think About Suicidal Patients?

• Attitudes towards suicidal patients are more positive in mental health professionals when compared to health professionals in other specialties
• ED nurses voiced resentment when asked to care for a suicidal patient
• Believe that if a patient really wants to commit suicide s/he will not tell anyone
• It is not possible to know who will commit suicide
• People should have the right to take their own lives
• Nurses appear to have somewhat more negative attitudes towards suicidal patients than other health care providers

  (Hjelmeland & Krizek, 2004)

What Usually Brings a Patient to the ED for Mental Health Care?

• Feeling out of control
• Relationship problems
• Being very afraid

  (Allen et al, 2003)
What is it Like to Be a Suicidal Patient in the ED?
• Patients feel that staff is often disrespectful and do not listen to them
• 53% believe that staff is not prepared to treat psychiatric emergencies
• Overuse of restraints and seclusion
• Felt ignored
• Uncomfortable being placed in a gown
• Forced to take medication
• Ancillary staff is often more compassionate than medical and nursing staff
  (Allen et al, 2003) and (Cerel, Currier & Conwell, 2006)

“Because I tried to kill myself by overdosing with alcohol and medications, I was treated meanly and the staff was cold. The police were laughing and joking with each other about what a loser I was”

“The nurse asked me what kind of mother could I be, doing this to my children?”

What Can I Do Better When Treating Suicidal Patients?
• **Listen** to the patient and his/her version of events
• Spend enough time with the patient to address questions
• Explain proposed treatments
• Ask the patient what has or has not worked for them in the past (medications)

What About Restraints?
• Patients felt restraints were used too long
• Staff did not respond to their questions or requests
• 54% of patients placed in restraints reported unwillingness to seek treatment in the future (Allen et al, 2003)
• Do not immediately resort to using restraints
• Try to calm the patient before resorting to restraints
  – Decrease environmental stimuli
  – Allow patient to sit or stand where they are comfortable
  – Do not overwhelm the patient with multiple staff members
  – Ask the patient what type of treatment s/he wants

What Else Can I Do?
• Allow patient to remain in own clothing after checking for dangerous items, such as draw strings, belts and weapons
• Provide the patient with blankets and a pillow
• Provide food
• Allow the patient to walk around the ED with supervision
• Ask the patient if they need anything on a regular basis

What Do I Need to Be Aware of When Assessing for Suicide?
• Assessment starts with triage
  – Is the patient safe to wait for a bed unsupervised?
  – If no, make sure security or staff stays with the patient at all times
  – Suicidal behavior is an emergency
    • Ensure that the patient is seen in a timely manner
  – Do not trivialize self-harming behavior as nothing more than attention seeking
    • Death by suicide within one year of self-harming behavior is 66 times greater than that of the general population
      (Hawton, Zahi & Weatherall, 2003)

What Do I Need to Be Aware of When Assessing for Suicide?
• Patients may not immediately admit to being suicidal
• Hopelessness and previous attempts put patients at especially high risk for suicide
• Unsympathetic responses tend to escalate behavioral disturbances and negatively affect the patient’s engagement in treatment
  – Especially true in patients with borderline personality disorder (Hemmings, 1999)
• If a patient admits to a suicide plan you need to evaluate the expected outcome of the plan NOT the lethality of the plan
  – If the patient believes his/her plan will kill him/her then the patient is at HIGH risk
    (Clarke, Brown & Giles-Smith, 2008)

What If the Patient is Vague?
• Patients are not usually consciously evasive
  – May be scared, embarrassed, in denial, minimizing, and/or defensive
• Ask about current stressors, anxiety or fear, hopelessness, and suicidal thoughts
• Listen to the patient’s family, friends and significant others
• Observe body language
  – Anxiety, decreased concentration, insomnia, agitation, irritability
  – Agitation indicates a high risk for suicide
    (Simon, 2008)

How Can I Facilitate Communication?
• Use the following questions:
  – Are things so bad that you sometimes wish you did not wake up in the morning?
  – Do you wish you were dead?
  – Have you thought about harming yourself?
  – Have you made plans/preparations?
  – Have you been close to doing something?
- Have you done something? **
  • Evaluate need for urgent medical attention
    (Clarke, Brown & Giles-Smith, 2008)

Is There an Objective Way to Assess for Suicide Risk?

- The modified SAD PERSONS scale provides an objective way to measure risk
- There are 10 parts to the mnemonic
- Each “yes” answer scores one point

SAD PERSONS

- S) Sex: Is the patient a man?
- A) Age: Is the patient an adolescent or > age 55?
- D) Depression: Is the patient depressed?
- P) Prior History of Suicide Attempts?
- E) Ethanol Abuse?
- R) Rational Thinking Loss?
- S) Support System Loss?
- O) Organized Plan?
- N) No Significant Other?
- S) Sickness: Chronic or painful illness?
  - Juhnke (1994)

**Scoring SAD PERSONS**

<table>
<thead>
<tr>
<th>Score</th>
<th>Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-2</td>
<td>Very low risk: encourage counseling and allow to go home</td>
</tr>
<tr>
<td>3-4</td>
<td>Low risk: encourage close follow-up and counseling</td>
</tr>
<tr>
<td>5-6</td>
<td>Moderate risk: consider hospitalization involuntary or voluntary, depending on your level of assurance patient will return for follow-up</td>
</tr>
<tr>
<td>7-10</td>
<td>High risk: definitely hospitalize involuntarily or voluntarily</td>
</tr>
</tbody>
</table>

(Juhnke, 1994)

Remember, mental illness is far-reaching and touches the lives of many people and their families. Mental illness and suicide does not discriminate based on gender, race, occupation, age or status.
REFERENCES


Zaheer, J., Links, P., & Liu, E. (2008). Assessment and emergency management of