THE IMPACT OF PATIENT SUICIDE
ON MENTAL HEALTH NURSES

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Originality Declaration

I declare that the work presented in this thesis is, to the best of my knowledge and belief, original and my own work, except as acknowledged in the text and reference pages.

Signed: ___________________________ Date: 27 May 2015
Abstract

The impact of patient suicide on mental health nurses

The aim of this research was to gain knowledge of individual nurses’ experience of a patient suicide and ascertain if this had an impact on them or their practice. The purpose of this research was to ensure mental health nurses are aware of supports available to them as health professionals after a patient takes their own life. The objectives of this study included determining if a patient suicide had an impact on mental health nurses, what support was offered to them and what was beneficial, or what support could potentially be useful after a patient suicide.

This research project sought to determine if there is an impact on mental health nurses when a patient dies by suicide and what support is available, using a descriptive survey methodology. Data was collected using a questionnaire developed specifically to ascertain if there was an impact on mental health nurses after a completed patient suicide, and what support participants found most useful. The quantitative data was analysed using descriptive statistical analysis, with thematic analysis applied to the free text answers providing qualitative data with emerging themes.

With the use of the Impact of Event Scale – Revised (IES-R) and its correlation to Post Traumatic Stress Disorder, this study shows a negative impact on mental health nurses within the intrusion subscale of the criteria for PTSD. Of the 58 eligible participants who completed this survey, 38% (n=22) scored more than 25 on the 88-point IES-R scale, indicating a group at high risk of experiencing PTSD. Themes emerged from free text answers determining immediate and on-going peer support was found by the participants of this study to be the most beneficial, ‘what the nurse needs’ was considered to be the most useful support.

This study highlights that mental health nurses, if not adequately supported after experiencing a patient suicide, have the potential to develop symptomology that correlates to criteria defined in the Diagnostic and Statistical Manual of Mental Disorders 4th Edition (DSM-IV) for Posttraumatic Stress Disorder.
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Chapter One: Introduction

Suicide

It is not known who the first person to take their own life was however it is a fact that humans learn through imitation and so suicide continues to be an issue today (Jamison, 2000). Historically suicide was referred to as a “solution of last resort” or “self-murder” bringing with it horrific stories and beliefs based on cultural, religious and legal sanctions (Jamison, 2000). At some point early in history suicide changed from being an accepted or valued event, where it was considered heroic to take one’s own life to prevent capture or dishonour, to being regarded as a sin or crime (Jamison, 2000). This in turn meant that funeral rites were denied, often bodies were desecrated before burial then (in many countries) buried during the night at a crossroads to ‘keep the body down’ and prevent the spirit from finding its way home (Jamison, 2000).

As time progressed and attitudes changed, suicide began to be considered by the judicial system and the public as the act of an unbalanced mind, as opposed to being due to weakness or a personal sin (Jamison, 2000). Bodies of those who took their own lives were now buried in cemeteries along with society’s other disreputable, but only on the north side of churchyards (Jamison, 2000). By 1800 essentially all of England’s suicide cases were judged to be ‘non compos mentis’ or ‘due to insanity’, which also became the case in the United States (Jamison, 2000). During the eighteenth and nineteenth centuries the majority of European countries had formally decriminalised suicide, however it remained a crime in England and Wales up until 1961 and in Ireland until 1993 (Jamison, 2000). As with all literature about suicide, there is that which is now known; who, how, where and when people end their lives, and that which remains unknown - why people take that fatal last step.

Researcher’s interest

I am a Registered Comprehensive Nurse who graduated in 2008 and began working as a Registered Nurse in 2009. My chosen area of practice at that time was mental health and I’ve worked in this area ever since. While working within an emergency psychiatric team I began to hear more and more about the quiet killer – suicide. At this point I thought back to my own experiences of patient suicide and began to question the effect this had had on me and the possibility that other mental health nurses felt the same. Thinking back to my first experience of a patient suicide and how unprepared I felt to deal with the situation, I recalled the paper on
‘bereavement’ offered (but not compulsory) during my undergraduate training. I began to question whether my experience would have been different if I had invested in this paper and to ask myself if bereavement was something that could be taught or needed to be experienced. This raises the question of are those who work in the area of mental health, particularly nurses, prepared in their training for the inevitability of a patient suicide and any impact this could have on them. So the topic for my thesis came about based on this reflection of my practice and along the way has developed into considering grief and its impact. Midence, Gregory and Stanley (1996, p. 119) provide an apt description of this topic in their statement “A qualification in a mental-health discipline does not infer resilience during distress either related to work or the personal life”.

Working in the area of mental health terms such as ‘suicide’, ‘suicide attempt’ and ‘suicidal ideation’ are often common everyday words. Despite attempts to destigmatise mental health in general, where existing ideas have come from horrific stories and pictures from historical asylums, suicide continues to be a taboo subject for many people and cultures today. Some believe if they talk about suicide it will occur, some (often those who have not experienced it first-hand) believe it is a selfish thing to do, and others just struggle to understand the concept at all and believe it will never affect them or those they love. Unfortunately suicide is a global phenomenon that impacts many lives every year.

Research question

“What is the experience of mental health nurses in relation to patient suicide and what support is needed?”

Aim, purpose and objectives

The aim of this research was to gain knowledge of individual experiences of mental health nurses in relation to patient suicide, the impact (if any) on them and their practice, what support they received and what they felt was needed. The purpose of the study is to ensure that mental health nurses are aware of what support is available when dealing with patients that take their own lives. The objectives of this study were:-

- To determine if there is an impact on mental health nurses when a patient dies by suicide
- To determine what support was offered at the time of the event, what support was most beneficial, what was least helpful and what could be useful in this situation
• To gain any further knowledge from nurses who have experienced a patient suicide to help educate and empower others.

Significance of the research

Despite suicide at times being an unavoidable part of mental health nursing the issue remains whether nurses are supported during and after this event and the impact this can have on future practice. The literature review will show that there is a significant amount of research in relation to suicide but very little relating to mental health nurse’s experiences, especially in New Zealand.

Relevance to mental health nursing practice

Shneidman (as cited in Valente, 2003) stated;

The person who commits suicide puts his psychological skeleton in the survivor’s emotional closet – he sentences the survivor to deal with many negative feelings and, more, to become obsessed with thoughts regarding his actual or possible role in having precipitated or failed to abort the suicide.

Some of the strongest risk factors for suicide are psychiatric disorders, with psychiatric inpatients constituting a high risk group for suicide attempts (Takahashi et al., 2011). Because of this, nurses working in the area of mental health are more likely to work with those who have suicidal ideation and attempt or complete suicide, than nurses working in other areas (Takahashi et al., 2011). Valente and Saunders (2002) highlight that ‘clinician bereavement’ surrounding patient suicide is rarely discussed in the literature as does Foley and Kelly (2007) who also note the lack of discussion and paucity of research literature about the effects on mental health workers. Robertson, Paterson, Lauder, Fenton and Gavin (2010) state that although the effects of patient suicide on staff are recognised, much of the available literature does not address any emotional or psychological impact in any depth. Robertson et al. (2010) also state that nurses’ descriptions and experiences of the impact of a patient suicide remain ‘relatively under-explored’. Gaffney et al. (2009) specifically mention nursing as a professional group that has little available research on the experience of patient suicide. Dearden (2004) describes literature around this topic as being sparse, despite statistics identifying nurses as being the largest body of health professionals working in the mental health sector.
Chapter summary

This chapter has introduced the topic of this thesis by examining historical information on suicide and by providing an outline of the researcher’s personal background and interest in this topic. The research question, aim, purpose and objectives of the study follow on from this introduction with justification for the study and its relevance to mental health nursing practice.

Chapter two is a literature review summarising the research available on mental health nurses and patient suicide and also includes research involving other health professionals and suicide due to the limited literature available relating to nurses only. Chapter two also addresses the issue of support after a patient suicide, along with a current overview of suicide and suicide statistics. Chapter three provides information on the research design and methodology used in this research along with a description of the measurement tool utilised in the survey to ascertain the potential impact and symptomology of patient suicide on mental health nurses. Summaries of ethical considerations and data analysis conclude this chapter. Chapter four presents the findings of this research project with quantitative data and free text qualitative data obtained from the questionnaire specifically developed for this research. Chapter five is the discussion chapter comparing the literature to the findings of this study, identifying both links and gaps in the literature and practice. Chapter six provides a conclusion of this research and acknowledges the limitations of this study.
Chapter Two: Literature Review

Chapter Two presents a review of the current literature on the effects of a patient suicide on nurses and other health professionals and raises the issue of support. This chapter also provides a current overview of suicide and statistics for a clinical phenomenon that has become a global health problem.

The purpose of a literature review is to determine what research is available on a particular topic of interest (Polit, 2010). From this gaps in knowledge can be identified, aiding in the formation of research questions and ensuring a potential contribution to practice can be made. A literature review can help build a foundation for studies while inspiring new ideas for research (Polit, 2010). Schneider, Whitehead and Elliott (2007) describe a literature review as the thread linking research, practice, theory and education; essential concepts in the development of disciplines. They state that the purpose of a literature review is to define a knowledge base for clinical practice, a theoretical perspective, or in the guidance of original research (Schneider et al., 2007). Parahoo (2006) places emphasis on the type and quality of information being gathered for a literature review with its value dependent on the source i.e. primary, secondary or tertiary. This inherently highlights the importance of accessing literature from reliable and credible sources.

During the literature review the author originally began looking for articles from 2010 however due to a lack of results this was extended to 2000. This provided more options however it quickly became apparent that a lot of the research on this topic is older than 2000. An example of this is Midence et al.’s (1996) study which is cited in many of the more recent articles and appears to be somewhat of a ‘cornerstone’ for research in this area. It is important to note that the references used in this article range from 1978 to 1994 and mental health nursing has seen enormous changes since that time. At the time Midence et al’s (1996) article was published there was a paucity of literature on suicide and the attitude and effects this had on mental health nursing staff, which continues to be an issue today. It is for this reason that the initial search date was extended to 1990 allowing literature from this decade to be incorporated in the review.

Search strategy

The databases searched included CINAHL, Cochrane, Medline Complete, Pubmed, Proquest and Google Scholar using the keywords; patient suicide, nurse’s experience, mental health / psychiatric nurse. Full text and peer reviewed articles in English were accessed, exclusions were those on assisted suicide and self-harm/injury.
Much of the available literature on this subject suggests reoccurring themes of emotional distress experienced by health professionals working with clients who have completed suicide. The literature on suicide and its impact is based on either the nurse’s perspective of the experience or that of other health professionals involved in the care of the client. Therefore this literature review has been divided into two sections; nurses’ experience and health professional’s experiences.

**Nurses experiences of patient suicide**

What appears to be considered the ‘cornerstone’ of research in this area is Midence et al.’s (1996) article on ‘The effects of patient suicide on nursing staff’ which is cited in much of the available literature to date. From their literature review they concluded there was overwhelming evidence that meetings between nursing staff, doctors and managers were needed to provide emotional support after a patient suicide, and more formal assessment processes of psychiatric patients was required (Midence et al., 1996). In relation to this research 77 questionnaires were sent out (within the UK), with only 27 returned (response rate 39%), and thematic analysis was done to produce four themes; effects of suicide on nursing staff, coping strategies, assessment of patients and prevention, and finally investigation and publicity following a suicide (Midence et al., 1996).

The first theme highlighted feelings of sadness, helplessness, shock, guilt, anger, frustration and fear respectively with the exception of six nurses that stated the patient suicide had not affected them (Midence et al., 1996). In relation to the second theme of coping strategies, 85% of the participants stated they coped with a patient suicide by talking to other colleagues, or partner at home, due to a lack of formal support (Midence et al., 1996). All participants thought there should be some form of individual or group counselling allowing them to express their feelings with further suggestions of staff meetings (majority believed hospital managers should be in attendance), support meetings, guidelines to manage suicide events with more support from senior staff, doctors and managers, and more education / knowledge around suicide issues (Midence et al., 1996).

The third theme of assessment and prevention produced some interesting results and a divide in opinions from the nurses involved. Firstly, 75% of the nurses thought it was the patients right to commit suicide as a personal choice, with 63% believing this was due to hopelessness and 55% due to depression resulting from living with a mental illness (Midence et al., 1996). The second issue was that 55% of the nurses felt that suicide could not be prevented, with 45% believing it could be prevented if patients were assessed for ‘suicide risk’ (Midence et al., 1996). Of course it
must be taken into account that this study was done nearly 20 years ago, and in the author’s opinion if repeated today these statistics may well be very different due to advances in technology and medications.

The final theme of investigation and publicity showed that 95% of the respondents felt like they were the ones on trial which produced feelings of guilt, along with the same percentage of nurses believing other patients should be informed of the incident (Midence et al., 1996). In addition to this, 85% of the nurses felt that managers were looking for someone to ‘blame’ and the same percentage stated their quality of work was affected in a negative way by publicity following a suicide (Midence et al., 1996). In conclusion Midence et al. (1996, p. 120) state “Employers need to acknowledge that nursing staff and mental-health professionals in general may experience emotional difficulties, which they may not express for fear of being seen as incompetent and professional and psychological support should be provided.”

Takahashi et al. (2011, p. 1) stated their results “indicated that nurses exposed to patient suicide suffer significant mental distress”. The aim of this research was to examine stress in nurses post-suicide and consider what suicide related mental health services and education were available (Takahashi et al., 2011). This research was undertaken through an anonymous survey questionnaire distributed to psychiatric nurses working in eight psychiatric medical institutions in Japan and cooperation was requested (verbally and in writing) by management of the medical institutions; explaining the extraordinarily high response rate of 94.5% (Takahashi et al., 2011). This research focussed on inpatient suicides and of the 531 respondents, 292 (55%) had experienced a completed suicide, with 40 individuals scoring 25 or higher on the 88-point Impact of Event Scale – Revised (IES-R); a well-documented post-traumatic stress symptom scale (Takahashi et al., 2011). Of the 292 nurses who had experienced an inpatient suicide, 234 (80%) of the respondents stated that no mental health care programmes were implemented to support nurses following the incident (Takahashi et al., 2011). To determine the availability of health care services and education, respondents were asked to list the topics of in-services they had attended in the previous three years; the top two on-site seminars/workshops were ‘psychiatric diseases’ and ‘risk management’, 60.3% (N=320) and 54.4% (N=289) respectively (Takahashi et al., 2011). The on-site seminar ‘suicide and suicide prevention measures’ was fifth on a list of eight support systems mentioned, with an attendance rate of 26.4% (N=140), ‘stress-coping methods’ was sixth with 16.9% (N=90) attendance and ‘mental health care for nursing staff’ came in at seventh on the list with a rate of 12.8% (N=68) (Takahashi et al., 2011).
Takahashi et al. (2011) concluded that there were no formal systems in place to determine the psychological effect on nurses when a patient died by suicide, which they believe relates to limited post-suicide mental health care programmes and education initiatives (Takahashi et al., 2011). Interestingly they also raised the issue in regards to public perception where nurses are seen to be givers of health care rather than receivers of it, tying into the idea that perhaps nurses don’t speak up about their feelings for fear of ‘disclosing a weakness’ that could damage their reputation as a professional. Takahashi et al. (2011) believe that postvention activities should be available for staff to have a voice, to provide support, share grief and aid in reducing self-blame and excess responsibility. In the particular medical institutions surveyed in this research, it was highlighted that awareness is lacking in relation to the impact of a patient suicide on nurses, along with the need to educate nurses in suicide related issues (Takahashi et al., 2011). Despite this research being carried out in Japan, which has an impact on its generalizability due to demographics and cultural aspects, it is extremely relevant to this research topic.

Talseth and Gilje (2011) conducted a metastudy of 26 research based nursing studies examining nurses’ responses to suicide and suicidal patients, which was guided by critical interpretive synthesis. The authors stated that suicide rates have increased by 60% since 1960 and that in the year 2000, depression (a known risk factor for suicide), affected 121 million people worldwide (Talseth & Gilje, 2011). Depression, ranked fourth in the Global Burden of Disease in 2000, is projected to reach second place by the year 2020 (Talseth & Gilje, 2011). Of the studies reviewed from the period 1988-July 2009, most emerged from North America and Europe (Talseth & Gilje, 2011). A total of 2667 participants were identified with the majority (40%) of these being oncology nurses and the least (10%) being psychiatric nurses, despite many of the studies (46%) having been conducted in psychiatric settings (Talseth & Gilje, 2011).

Talseth and Gilje (2011) acknowledge the contextual gaps in international research reporting high rates of suicide in areas such as Sri Lanka, Russian Federation and Baltic States (according to statistics), however no evidence of nursing research on this topic has come from these places. Talseth and Gilje (2011) identified four key concepts arising from their research being; critical reflection (confronting own frustrations, needs and desires), attitudes (related to age, experience, specialty, religion and education), complex knowledge/professional role responsibilities (ethical-legal considerations) and desire for support/resources (emotional and educational). The authors conclude that these four concepts can be a ‘useful guide’ to help understand nurses’ responses to suicide and suicidal patients, and assist in facilitating suicide prevention and recovery in relation to this growing public health problem (Talseth & Gilje, 2011).
Robertson et al. (2010) reiterate the lack of literature on the psychological or emotional impact of suicide on staff in any real depth (despite the effects being recognised), and that nurses experiences remain relatively underexplored. Robertson et al. (2010) used a discourse analysis approach when examining the experience of two female Registered Mental Nurses working in the same acute psychiatric ward in Scotland that had experienced the same patient suicide. The focus of the analysis was to determine how accountability was constructed from the meaning of the nurse’s stories in relation to the patient suicide, showing that people can utilise and alternate between different discursive strategies to portray themselves and their version of events as more believable and harder to question (Robertson et al., 2010). They question whether nurses internalise expectations around suicide which are potentially unrealistic, blaming themselves for events that couldn’t reasonably be foreseen and prevented in the short term in a psychologically unhealthy manner (Robertson et al., 2010). The authors conclude that this study provides some evidence of lasting effects on the participants from patient suicide and that clear support strategies are necessary (Robertson et al., 2010).

Bohan and Doyle (2008) describe shock, anger and frustration as being the main feelings reported by nurses after a suicide or suicide attempt. This was a qualitative descriptive study where the nine participants were psychiatric nurses working within acute psychiatric units from three hospitals in Ireland (Bohan & Doyle, 2008). Feelings of shame and guilt were also experienced when anger was directed at nurses by family members, along with anxiety, panic and feeling frightened after the event (Bohan & Doyle, 2008). One participant from this study identified that each suicide / suicide attempt is unique; such as the patients personality and circumstances, however Bohan and Doyle (2008) suggest that the feeling of ‘panic’ may be eased with experience of the situation. Another participant noted that following a suicide there was a marked increase in patients on the same ward attempting suicide at times when nurses were otherwise occupied, such as when shifts were changing or at meal times; this idea is not new within the literature (Bohan & Doyle, 2008).

Participants in Bohan and Doyle’s (2008) study considered that some form of support was essential after a traumatic incident with the most identified one being ‘peer support’, provided in a casual rather than a formal manner. Family support was considered useful in the event of a significant occurrence, however in terms of formal support from management the idea of “having a break from the ward immediately after the incident for at least a day or more” was noted to be of benefit (Bohan & Doyle, 2008, p. 14). Participants also suggested the idea of ‘protected time’ to aid in discussing the incident and enable reflection on practice along with ongoing education around suicide, a team building exercise after an event, and a three or six
month post-incident analysis to ensure those involved were coping with any potential after effects (Bohan & Doyle, 2008). The importance of talking about an incident as soon as was possible after the event was identified by Bohan and Doyle’s (2008) study participants due to the ‘freshness’ of it in everyone’s minds. In conclusion, Bohan and Doyle (2008) reiterate the difficulty in predicting suicide and the emotional impact nurses can experience following a patient suicide.

Dearden (2004) explored the lived experiences of five mental health nurses; four male and one female, who all worked within one District Health Board in New Zealand and who had experienced a patient die from suicide. These nurses had between 10 – 20 years’ experience in nursing and even though they had all worked in both inpatient and community settings chose to discuss a suicide that occurred while working in a community setting (Dearden, 2004). Narrative interviews were conducted where emotions such as shock, guilt, anger and sadness were described by the participants, as well as a self-described significant impact (Dearden, 2004). Common to all five participants was a feeling of lack of ‘closure’ relating to the coronial procedure, which left them with unanswered questions, on-going dissatisfaction and often inconclusive processes (Dearden, 2004). From the interviews five interwoven themes of impact, support, feelings, closure and paradox emerged (Dearden, 2004).

Dearden (2004) identified three main paradoxical themes described by the participants; unavoidable – responsible, inevitable – unprepared, and duty of care – respect for patients decision to end their life, resonating with other research (Takahashi et al., 2011; Loos et al., 2014; Midence et al., 1996). Dearden (2004) states that all the nurses were unprepared for a personal experience of suicide and that they could respect and understand a patient’s decision to end their life, however found this the most difficult aspect to accept. The suicides discussed by the participants had occurred between 2 to 12 years ago with the result of one nurse leaving clinical practice and two making changes to their nursing practice (Dearden, 2004).

In terms of support, one participant described (at length) the importance of collegial support to them, another accessed existing clinical supervision, and another found a 1:1 debrief supportive (Dearden, 2004). Support from colleagues was seen as being beneficial by one participant, compared to that sought from family and friends, who had difficulty understanding the feelings and issues raised by a patient suicide (Dearden, 2004). Among the participants, when referring to debriefing the following aspects were described; a sense of ‘covering up’ by service management, a feeling that it was about the process rather than people’s feelings, the involvement of those who had nothing to do with the deceased, and one participant who thought
debriefing was an improvement on the ‘nothing’ they had had previously (Dearden, 2004). The general consensus from the participants was that debriefing was of little use and was thought to add more stress to the situation (Dearden, 2004). When asked what participants thought should be available, responses included; flexible support to meet the needs of individuals and an identified senior team member to ensure support is provided when needed, including follow up at a later date for potential adverse effects i.e. identifying the body was reported to have had a significant impact for one nurse (Dearden, 2004).

The idea that nurses do not seek support after a patient suicide must also be considered; Dearden (2004) questions this by suggesting nurses consider it a weakness to ask for help, Midence et al. (1996) suggests that health professionals may not express emotional difficulties for fear of being seen as ‘incompetent’, Gerow et al. (2010); Wilson and Krishbaum (2011) (as cited in Loos et al., 2014) consider nurses are in fact their own biggest obstacles when it comes to receiving support as they push aside their feelings to ‘get on with things’.

Dearden (2004) concluded by stating all the nurses who participated in this study identified that patient suicide had a significant impact on them and was influenced by things such as the quality and length of the relationship with the patient, how the nurse was informed about the suicide and whether or not this event had been expected. Recommendations from Dearden’s (2004) research included; mental health services having a suicide response policy, education on the impact of patient suicide in undergraduate training, promotion of dialogue around suicide in the community by policy development and a need for further research in this area.

The aim of Joyce and Wallbridge’s (2003) study was to gain insight into the effects on nursing staff of three ‘critical incidents’ (two ended in death and all occurred within a six month period) that were associated with a psychiatric unit in Canada where suicide had until that point been a rare occurrence. The study sample consisted of nine members of the nursing staff who were involved with one or more of the events, using a qualitative interview technique to obtain a deeper understanding of the experiences of the nurses and their reaction to patient suicide (Joyce & Wallbridge, 2003). The authors noted when approaching nursing staff to seek participants for their research they felt there were others affected by the incidents who declined to participate, this could therefore underestimate the effects on nursing staff (Joyce & Wallbridge, 2003).

Once socio-demographic and level of involvement with the incidents had been ascertained, Joyce and Wallbridge (2003) analysed the responses from the nine participants in relation to effects of the critical incidents. Feelings of sadness, shock, stress and emotional reactions such as anger, fear and irritability were reported by the participants, and all but one believed their co-workers had been affected to some degree (Joyce & Wallbridge, 2003). Participants also
believed that a “split” occurred between staff where some felt threatened or blamed, as well as blaming each other causing tension and anxiety within the work place (Joyce & Wallbridge, 2003). The ‘splitting’ referred to above was described as members of staff blaming each other, or criticism of how colleagues had dealt with the incidents, where terms such as ‘scapegoated’ and ‘ostracized’ were mentioned (Joyce & Wallbridge, 2003). Alongside this, ‘splitting’ was also seen to occur when there were differences of opinion about the best approach to adopt after the event occurred in relation to talking or not talking about the incident (Joyce & Wallbridge, 2003).

Nine of the participants from this study stated they changed their clinical practice because of the critical events; they noted an increase in policy and protocol adherence, they became more vigilant and their trust in their patients decreased (Joyce & Wallbridge, 2003). Participants also noted a change in colleagues practice; clinical and assessment skills were increased, patient’s whereabouts were more closely monitored and policies and procedures regarding passes (known as ‘leave’ in New Zealand) were more strictly adhered to (Joyce & Wallbridge, 2003). Unfortunately the negative side of this was that staff members became overly guarded and vigilant to the point of rigidity in their practice, which in turn affected the patients freedom and delayed discharges, altering the general atmosphere of the unit to a negative one (Joyce & Wallbridge, 2003).

Another important consideration in this study was the variation in individuals reactions which was influenced by the nurses proximity to the event i.e. the more they had to do with the actual event the greater the psychological effect (Joyce & Wallbridge, 2003). Other factors that came to light were points such as the psychological resilience of each nurse (personality), positive reframing (valuing life after experiencing death), renewed job commitment, deteriorating team cohesion and identification with the patient or their family (age group, gender) (Joyce & Wallbridge, 2003). The authors acknowledged the considerable diversity in how patient suicide affects staff members and the difficulty of imposing standardised protocols to deal with work related stress (Joyce & Wallbridge, 2003). In saying that, the authors believe that there remains a need for organised programmes within health institutes to provide short term, urgent debriefing and counselling for staff affected by critical incidents such as a patient suicide (Joyce & Wallbridge, 2003).

Valente and Saunders’ (2002) article is a review of literature examining the incidence of patient suicide, the reactions of clinicians to suicide, as well as bereavement theories and postvention options. They define suicide as “an intentional, self-destructive, self-inflicted act that causes death” (p. 5) and postvention as “a term that refers to preventative interventions for survivors who grieve a death by suicide” (Valente & Saunders, 2002, p. 6). Due to a lack of literature
around nurse’s responses to patient suicide, comparisons are often made to psychiatric trainees and psychiatrists, despite nurses having different relationships with patients and potentially different reactions to suicide. Valente and Saunders (2002) review of the literature included only two studies directly related to nurses; Hamel-Bissell’s study done in 1985 and Midence et al.’s 1996 study where feelings such as fear, anxiety, helplessness, confusion, responsibility, sadness, anger, frustration, shock and guilt were described. Valente and Saunders (2002) conclude that this is a traumatic time for nurses, adding fear of legal repercussions, family reactions and competence issues, while reiterating the need for support to help cope with grief after a patient suicide. They also believe that gaining knowledge of bereavement and accessing support helps prevent negative effects, such as stress and burnout, while allowing nurses the opportunity to learn to cope constructively with their grief and process it (Valente & Saunders, 2002).

Loos, Willetts and Kemp’s (2014) article was based on the reflections of a student nurse in Australia who experienced a patient die by suicide and her feeling of sadness, anger, guilt, professional incompetence and grief that followed. The aim of this paper was to examine nurse grief, available support and consequences of unaddressed grief using Doka’s 1987 theory of disenfranchised (or unacknowledged) grief (Loos et al., 2014). Using a reflective model Loos et al (2014) described the student as having feelings of ‘unpreparedness’ (first experience with a patient death), a sense of shock, a feeling of guilt and a level of anxiety, which led to seeking peer and educator support. The student felt that the biggest challenge came from the lack of available support in dealing with the resulting grief rather than the actual death itself, however it is pertinent to note here that the student did not witness the suicide but was the last person to see the patient alive (Loos et al., 2014).

Loos et al. (2014) believe it is imperative that nurse’s grief is recognised, acknowledged, accepted, appropriate support put in place and nursing education improved to prevent the compounding of serious adverse effects of unaddressed grief. Loos et al. (2014) reiterate the many emotional, physical, behavioural and cognitive symptoms a nurse can experience when a patient dies by suicide and also the depth of the relationship from on-going care provided. Wilson and Kirshbaum (2011) (as cited in Loos et al., 2014) state that personal experiences of death can impact on nurses attitude, approach and how they deal with death and dying; suggesting that a negative personal experience of death which was unresolved or unaccepted, has the potential to manifest in unresolved grief.

Loos et al. (2014) suggest both formal and informal debriefing as being the most common support mechanisms for nurses experiencing a grief response, along with training and education around death, dying and nurse grief. The authors discuss the consequences of unaddressed grief
as ‘disenfranchised grief’, where nurses rely on their own internal methods of coping after a patient death (often dealing with intense emotions) due to lack of acknowledgement and support, which can lead to maladaptive coping strategies. The cumulative effects of unresolved grief can have far reaching implications for the nurse, patients, work environment and potentially the nursing profession (Loos et al., 2014). The authors state “The culture of nursing needs to change in order to adequately support nurses dealing with patient deaths – this will only occur once supports are widely available and nursing education acknowledges the grief response and teaches positive coping mechanisms” (Loos et al., 2014, p. 195). In conclusion Loos et al. (2014) identified that nurses ‘most popular choice’ of support after a patient death was informal debriefing with peers, and state that although the theoretical literature suggests formal debriefing as having merits, often practical, logistical and cultural issues can hinder its use.

**Health professionals experiences of patient suicide**

Gaffney et al. (2009) looked at the impact of suicide on front-line staff which included psychiatry, psychology and psychotherapy, community mental health, general practice and EMT’s (Emergency Medical Technicians) in their study. This study was based on a survey completed by 447 frontline professionals’ in Ireland in relation to patient suicide and aimed to examine the distress caused by this with a focus around on-going support and training required (Gaffney et al., 2009). This article begins by addressing a debate within the literature about whether bereavement as a result of suicide is different to mourning in general (Gaffney et al., 2009). Jordon (2001) (as cited in Gaffney et al., 2009) reviewed the literature on this issue and came to the conclusion that bereavement following a suicide differs due to; themes associated with the death (guilt, responsibility, difficulties families face finding meaning and acceptance), social impact of the death (isolation and stigma, suicide still considered ‘taboo’ in Ireland), and the impact of the death at the family level (disruptions to family interactions and increased risk of suicide in family) (Gaffney et al., 2009).

Gaffney et al. (2009) sent out 2,100 anonymous questionnaires consisting of both quantitative and qualitative items and had a response rate of 21%. At 46% nursing was the most represented group in the study with psychiatry and emergency medical staff having experienced the most suicides (Gaffney et al., 2009). The authors cite anger, guilt and sadness as being the predominant emotional responses reported, along with physical and psychological symptoms associated with trauma, such as lack of concentration, irritability, sleep loss (which were all reported by both sexes), however professional self-doubt was expressed more often by women.
(Gaffney et al., 2009). Participants believed that the type of relationship they had with a patient was a key factor in how the suicide affected them, following this was support from peers, supervisors and management they received (Gaffney et al., 2009).

In terms of gender differences, Takahashi et al. (2011, p. 7) state “It is generally reported that female nurses are at a higher risk for PTSD and related conditions than male nurses”. Kovac and Range’s study (as cited in Valente & Saunders, 2002) report that “female clinicians feel more shame and guilt and seek more consolation than males.” Gaffney et al. (2009) reported that men appeared more likely to report that suicide didn’t have an effect on their functioning as opposed to women, women suffered greater professional self-doubt and had greater support and counselling needs than men.

According to the authors of this study, a close therapeutic relationship with the patient, concerns for bereaved family and feeling responsibility for the death were key factors that influenced how health professionals coped and adjusted to a patient suicide (Gaffney et al., 2009). They suggest accepting suicide as a possible outcome (even if excellent care is provided), a need to normalise the emotions experienced after a suicide and take advantage of available supports and consider investigations as a learning experience rather than a blaming one (Gaffney et al., 2009). Gaffney et al. (2009, p. 652) state “There is no evidence base to recommend specific formal interventions in a routine manner.” In summary Gaffney et al. (2009) reported they were unable to provide any ‘blanket recommendations’ but rather suggested that each service create a supportive environment for those who need it taking into account themes of; anticipation, preparation and respect of individual differences.

Foley and Kelly (2007, p. 134) assert that “the effects of patient suicide on mental health workers are rarely discussed and research literature on this topic is sparse”. Their review of the available literature focuses on the incidence, effects, and coping mechanisms of patient suicide on mental health workers, in particular psychiatrists and psychiatric trainees. Foley and Kelly’s (2007) overall impression of the studies they reviewed was that a patient suicide had a significant effect on personal and professional lives of psychiatrists and trainees. From a nursing perspective this is also relevant; whether working in an inpatient or community mental health setting nurses often have a lot more day to day contact with patients (compared to consultant psychiatrists and psychiatric trainees), and sometimes because of this a stronger therapeutic relationship. Foley and Kelly (2007) state the effects of patient suicide on mental health workers are pronounced, prolonged, profound, and may significantly affect morale (Foley & Kelly, 2007).
Foley and Kelly (2007) concluded from the studies they reviewed that the majority of support the psychiatrists and psychiatric trainees derived was from informal contact with team members, family and friends. In terms of support from those outside the workplace, in particular family and friends, the necessity of confidentiality would prevent any in-depth discussions and ongoing support around the issue. From this viewpoint it is not clear whether support was sought from those closest to them because there were no formal support structures in place, or because it was what those involved found most useful.

Spencer’s (2007) study addressed the issue of support for staff after a patient suicide suggesting that the desire to support others comes from wanting to alleviate the immediate pain of the event and help prevent potential long term difficulties. One of the interventions Spencer (2007) discusses is that of debriefing and how the lack of a clear definition prevents evidence either for or against it in relation to its effectiveness. The author also raised the issue of there being a sense of responsibility or failure experienced by mental health staff if death is the outcome of a therapeutic relationship (Spencer, 2007). This was a predominantly a qualitative piece of research aimed at identifying any impact of a patient suicide on mental health professionals and to ensure effective support was available (Spencer, 2007). The 11 participants interviewed for this study included seven mental health nurses, two social workers, a support worker and a consultant psychiatrist (Spencer, 2007). Four themes emerged from the study; the first was the effects of the incident, where participants reported the actual death as being the most stressful aspect with informal team support being the most helpful (Spencer, 2007). The effects of stress was the second theme, which involved the participants completing a ‘Trauma Screening Questionnaire’ with the potential for this tool to be used again in a three to four week period following the suicide (Spencer, 2007). The third theme in Spencer’s (2007) study related to the use of facilitators, with the outcome that the participants were divided about whether support should come from managers or from outside the work environment. Finally, the participants were asked to answer the question about what they thought would was the best way to support staff producing the focus areas of explanation, choice, information and feedback (Spencer, 2007).

Spencer (2007) clearly states that the impact of a patient suicide varies considerably among staff from different professions and is not accounted for by things such as profession or experience. Participants from this study preferred space and individual support compared to formal debriefing and many of them also stated the importance of having a choice of support and an element of control over this (Spencer, 2007).
Bowers, Simpson, Eyres, Nijman, Hall, Grange and Phillips (2006) study aimed to examine the impact of Serious Untoward Incidents (SUI), which includes suicide, on acute psychiatric inpatient wards in England. In the United States the term ‘sentinel event’ is the equivalent of an SUI and is also a term that is more commonly known in New Zealand. An SUI within the psychiatric services in the UK is generally defined as “any incident where medical treatment was required or death occurred, or where moderate to high financial loss, or loss of reputation might occur” (Bowers et al., 2006, pp. 226-227). A cross-sectional interview survey of multidisciplinary staff from 17 units was conducted from which a total of 39 incidents were identified with 11 of these being completed suicides (Bowers et al., 2006). Staff spoke of the negative impact on morale that occurred after an SUI in a ward however when patients died feelings of upset, loss, grief and shock were described, followed by negative ruminations often leading to feelings of guilt and dismay (Bowers et al., 2006). SUI’s primarily involving death caused anxiety related to a feeling of potentially being blamed by managers and the general public for the death leading to worry and self-doubt (Bowers et al., 2006).

Participants from this study described three managerial responses as being helpful; support (both from managers and outside professionals providing counselling or facilitating discussions), investigation (discussion and debriefing with managers and the team), and change (introduced immediately or later as an outcome of an investigation (Bowers et al., 2006). An SUI was described as potentially providing both positive and negative effects on staff, such as more rigorously completed documentation or hesitation when issuing leave from the ward, leading to a heightened sense of alertness and vigilance (Bowers et al., 2006).

The authors concluded that “The findings confirm previous studies that staff suffer considerable stress and trauma as a result of patient suicides and other SUIs” (Bowers et al., 2006, p. 232). They suggest that staff prepare themselves in advance for these events, seek outside support after they have occurred and attend regular clinical supervision and appropriate training (Bowers et al., 2006).

Linke, Wojciak and Day’s (2002) study findings showed that the majority of responses from a confidential questionnaire in relation to patient suicide sent out to community mental health teams indicated significant adverse effects on the personal and professional lives of staff. A questionnaire was sent out to 77 staff members of five community mental health teams covering the London Borough of Islington, of the 44 responses received 18 were community psychiatric nurses (Linke et al., 2002). A range of symptoms and emotions were experienced by staff after a patient suicide however 15 (40%) of participants reported these continued for over one month (Linke et al., 2002). Another 17 (45%) participants reported long lasting effects on their
professional lives, with some of these serious enough to influence negative professional
behaviours (Linke et al., 2002). For those respondents who reported a noticeable impact on
their personal lives the three most common effects were; grief/sadness, preoccupation with work
and self-doubt/uncertainty, the three most noted in respondents professional lives were; anxiety
of work, self-doubt and avoidance of clients perceived as at risk (Linke et al., 2002). After a
patient suicide three respondents took time off work and a few reported positive effects such as
being more likely to seek support from peers and colleagues and improved note keeping (Linke
et al., 2002).

When the respondents from Linke et al.’s (2002) study were asked what their definition of
support was the majority (23 respondents) reported the concept of ‘having time to talk and
someone to listen,’ followed by skilled supervision (6 respondents), acknowledgment of the
impact of the event without blame (5 respondents) and the value of having time off (4
respondents). Support from immediate colleagues, partners, family and friends respectively
provided the most common source of support however it was reported that the most valuable
support was from peers, reviews, dedicated staff meetings and support received from senior
colleagues (Linke et al., 2002).

Cooper’s (1995) research examined the aftermath of both patient suicide and patient assaults on
psychiatric staff indicating that cognitive, affective and behavioural changes manifest in
symptoms of Post-Traumatic Stress Disorder (PTSD) and grief. After reviewing the literature
Cooper (1995) describes numerous parallels between assault and suicide however this thesis is
focussed only on the suicide aspect, where the patient is the victim rather than the staff member.

Cooper (1995) suggests that staff potentially experience ‘loss’ of self-esteem, trust and control,
and that grief is a response to this actual or perceived loss. This is followed with the idea that
because of the trauma experienced, staff can become avoidant, quality of care is affected and
‘formation of therapeutic relationships’ is hindered (Cooper, 1995). This research indicates that
patient suicide can cause more ‘affective’ responses such as helplessness, loss of self-
confidence, bewilderment, countertransference, crying, feelings of failure and sadness (Cooper,
actively suicidal and suffered from symptoms of depression that often accompany dysfunctional
grief.”

Administration or institutional reactions to a patient suicide can also impact on staff as can co-
worker reactions, and the nature of the relationship with the patient in regards to transference
and countertransference (Cooper, 1995a). These factors can exacerbate symptoms of PTSD and
grief which can potentially be manifested by a patient suicide (Cooper, 1995a).
Little (1992) published an article that included findings from a literature review around the issue of staff responses to inpatient and outpatient suicide. This was initiated as part of a proposal to introduce a ‘suicide audit’ at the Department of Psychological Medicine at Dunedin Hospital. This review suggested (based on limited literature) that clinicians pass through three individual phases following a suicide; ‘Phase I’ is the initial week after the event and can include feelings of disbelief, bewilderment, loss of control (in a general sense) and a fear of suicide imitation (Little, 1992). ‘Phase II’ begins in the first week after the event, continues over the next two month period, and is a time of turmoil with the potential for feelings such as anger, guilt, anxiety, depression and self-doubt and is reported to be the most difficult phase (Little, 1992). ‘Phase III’ extends over the period from two to six months with the intensity of the turmoil lessening and possible growth opportunities or prolonged disabilities to arise (Little, 1992). As with Kubler-Ross’s (1969) stages of dying theory, the phases mentioned by Little (1992) suggest a timeline of events with the reality that individuals may pass through the stages at different rates.

Despite the age of this article, it appeared that the literature at the time highlighted the importance of informal peer support as a valuable support system (Little, 1992), the more recent literature continues to do the same. Based on this research a protocol was designed to determine what happens after a patient suicide, placing the ‘psychological autopsy’ among the general context of post-suicide management (Little, 1992). Although this research was done based on a medical perspective rather than a nursing one, the feelings described in the different phases very closely resemble those documented in relation to mental health nurses experiences after a patient dies by suicide.

Suicide postvention is another term that is gaining recognition and describes activities that occur post suicide to help alleviate the impact on survivors (Aguirre & Slater, 2010). It is suggested that these activities can include (but are not limited to) individual therapy, group therapy and outreach to survivors of suicide (Aguirre & Slater, 2010). The primary benefit of postvention is to alleviate psychache (described in this article as intolerable psychological pain), with the secondary benefit of belonging or being connected to a group of others with similar experiences (Aguirre & Slater, 2010). Although Aguirre & Slater’s (2010) article was based on grieving the loss of a loved one by suicide, it closely resembles support recommended in the literature for health professionals who have experienced the loss of a patient from suicide.
Support

In relation to support, terms such as ‘Critical Incident Management Program’ (Joyce & Wallbridge, 2003) and ‘Critical Incident Stress Debriefing’ (Spencer, 2007), were used in articles published in specific geographical locations however words such as ‘supervision, support, debriefing, bereavement and Posttraumatic Stress Disorder’ (PTSD) appear to be universal. Interestingly, Spencer (2007) defines the original definition of ‘debriefing’ as an intervention approach and describes its direct correlation to PTSD.

Gaffney et al. (2009) report that peer support, time out and debriefing (respectively) were the most frequent form of support following a patient suicide with value being placed on support from immediate colleagues as opposed to unknown external supports. 32% of participants who had experienced a patient suicide stated they were not supported after the event, suggestions of support needed was; more training on suicide signs and symptoms and support in dealing with the aftermath, specific protocols and clearer guidelines and information for the health professional on their role and responsibilities (Gaffney et al., 2009).

Joyce and Wallbridge (2003) asked their study participants what supportive activities were most beneficial, the least helpful, and what would have been helpful both in and outside of the workplace and offer recommendations for interventions. When asked what participants found the most beneficial in terms of support, the majority agreed talking about the incident was best however differences of opinion were noted (Joyce & Wallbridge, 2003). Voluntary ‘ad hoc’ debriefings organised by onsite clinical staff were cited as being the least helpful, in particular the timing of these meetings, being held either too early or too late (Joyce & Wallbridge, 2003). General consensus (from seven of the nine participants) in regards to what would have been helpful was the suggestion of a debriefing either immediately after the event or within 72 hours of it occurring, with two staff believing it should be mandatory to attend (Joyce & Wallbridge, 2003). Other suggestions cited as being helpful were more information and managers providing a supportive stance (Joyce & Wallbridge, 2003).

The term ‘psychological autopsy’ has appeared a number of times in studies and according to Cooper (1995a) was introduced in the 1950s (specifically Los Angeles) to investigate suicides by clarifying mode of death, to certify the cause more accurately and potentially provide missed clues. The more recent use of the term psychological autopsy has seen the involvement of psychiatric teams for crisis intervention, and the Critical Incident Stress Debriefing (CISD) tool that has been used to assist emergency service personal cope with ‘repeated exposure to trauma’ (Cooper, 1995a). As a means of support for psychiatric staff, Cooper (1995a) suggested a
protocol incorporating both the psychological autopsy and the CISD known as ‘Psychiatric Stress Debriefing’ to assist psychiatric staff in alleviating the impact of patient suicide and assault. Taking into consideration this article was published in 1995 and the author was based in the United States, these are not terms or tools that are commonly used in New Zealand.

Farrington (1995) suggests that patient suicide has a potential impact on nurses and describes ‘psychological debriefing’ as an appropriate intervention when needed. At the time this article was published, psychological debriefing (also known as ‘critical incident stress debriefing’) was a relatively new concept and was developed based on the experiences of emergency service personnel faced with stressful incidents in their daily work (Farrington, 1995). The experience of death and dying in nursing has been identified as a major source of stress, therefore the suicide of a patient can be seen as a critical incident that may require intervention to potentially prevent ‘burnout’ (Farrington, 1995). The essence of psychological debriefing, as defined by Farrington (1995), is to view the experience of an emotional trauma as a normal consequence of an incident by putting the realities of a situation into context. Farrington (1995) sees the function of debriefing as being a crisis intervention to help manage psychological reactions to incidents while reducing the likelihood of lasting effects on a person’s everyday functioning. Farrington (1995) suggests that a debriefing should be held within two days of the event occurring to ensure memory recall of the incident is accurate, but also states that this can be done at any time.

Morris’s (1995) research is based on a case study of a 23 year old female who died by suicide in an inpatient setting, where the focus is on the aftermath of the event from a professional perspective. The basis of this research was to ensure there were appropriate systems in place when a suicide occurred and that all parties involved; relatives, other patients and staff, have an opportunity to reflect on the event (Morris, 1995). The author of this research acknowledges the difficulty of a professional reflecting on a suicide due to the associated trauma and questioning of competence, but also highlights the need for discussion around this to help resolve personal and professional questions that can arise, thereby improving future practice (Morris, 1995).

While reflecting on the review process Morris (1995) raises two issues that can be considered as vitally important; the first being that the process is not about finding out why the person committed suicide so much as looking at the overall degree of care and making changes if necessary. The other aspect is that in this particular case study the staff were traumatised by not only the fact that the suicide was unexpected, but that there was no identified risk (Morris, 1995). The patient was on visual observations, as is protocol for mental health inpatient settings, however she was deemed to be ‘low risk’ in terms of having suicidal thinking, a plan or
previous suicidal behaviours (Morris, 1995). Jamison’s (2000) research indicates that nearly 50% of those who die by suicide while an inpatient or immediately after discharge were assessed as being non-suicidal on admission.

Health professionals do their best to ‘save’ everyone, the inevitability is that there are those who don’t want to be saved which requires a level of acceptance. Little (1992) reiterates this by discussing an ‘inevitability about suicide’ at a population level, stating that despite preventative and treatment measures being put in place there will be a proportion of patients who will still end their own life. Gaffney et al. (2009) also agrees with this concept, adding that the suicide often occurs without detection. Jamison (2000, p. 153) summarises this by saying “Hospitals can provide sanctuary and medical care; they can save the lives of many who are suicidal. But they cannot save everyone.”

**Current overview of suicide**

The Ministry of Health (2013, p.2) state:

Multiple risk factors and life events are involved in a person ending their life. The link between mental illness and suicidal behaviour is well known, but other risk factors include exposure to trauma, a lack of social support, poor family relationships and difficult economic circumstances.

Evidence shows a definite link between psychiatric illness and suicide where numerous studies from Asia, United States, Europe and Australia have shown that “90 to 95 percent of people who committed suicide had a diagnosable psychiatric illness” (Jamison, 2000, p.100). Studies have also provided findings showing that hopelessness is closely related to the eventual suicide of depressed patients both in and out of hospital as well as being one of the most consistent warning signs of suicide (Jamison, 2000). Jamison (2000) suggests that people are able to ‘tolerate’ or ‘bear’ depression as long as they have hope and believe things will improve. Kubler-Ross’s (1969) work on the ‘death and dying’ of the terminally ill also talks of hope being the one emotion that persists through; denial and isolation, anger, bargaining, depression and acceptance, which she describes as being the stages of dying. Kubler-Ross (1969) writes about a sense of hopelessness, helplessness and isolation which accompanies the fear of dying, and that the death itself is not the problem. However it must be kept in mind that this perspective refers to those who have not chosen their fate and want to live, as opposed to those who willingly choose to die. Despite being at opposite ends of the spectrum, i.e. those who are dying and want to live, and those who are living but want to die, it appears that the emotions
mentioned by these two authors are very similar and are major determinants of how a person will ‘leave this world’.

Researchers from England analysed results of 250 clinical studies to compare those who suffered from specific mental illnesses and died by suicide with the number of suicides expected within the general population (Jamison, 2000). The findings of this research showed those with a history of a serious suicide attempt had an expected risk of being 38 times more likely to die by a subsequent suicide than the general population, making this the single most significant predictor of suicide (Jamison, 2000). The mood disorders, depression and bipolar, carry with them the highest danger of suicide, which increases even further when depression coexists with alcohol and/or drug abuse (Jamison, 2000).

Hunt et al. (2007) article reported on a case-control study investigating death by suicide in psychiatric inpatient care in England. The documented suicides occurred between April 1999 and December 2000 and consisted of 222 study participants that were matched with 222 living controls (Hunt et al., 2007). The authors reported hanging as the most common method of suicide, followed by jumping from a height or in front of a vehicle, less frequently by overdosing (paracetamol and other analgesics) then drowning (Hunt et al., 2007). In order of commonality of primary diagnosis from the most to the least were; major affective disorder, schizophrenia and personality disorder (Hunt et al., 2007). Of the 222 suicides, 45 occurred within a week of admission with the suicide more likely to be carried out on the ward or for the patient to have absconded from the ward, while 94 of the suicides occurred within four weeks of admission (Hunt et al., 2007). Interestingly, 113 patients died while off the ward after the first week of admission, with the majority of them (69) having left the ward with staff agreement (Hunt et al., 2007).

The results from this study indicated suicide predictors as being; male gender, diagnosis of affective disorder with a co-morbid psychiatric disorder (most often personality disorder or depressive illness), previous deliberate self-harm and adverse life events within the last three months (Hunt et al., 2007). The authors concluded that the first week of admission is the highest suicide risk period (Hunt et al., 2007).

Bickley et al. (2013) conducted a similar case-control study (with only 100 suicide cases and 100 living control group participants) to determine suicide risk and protective factors among patients in the two week period post discharge from psychiatric inpatient care. This study was also undertaken in England but over a three year period (January 2004 to December 2006), with
the assistance of the National Confidential Inquiry Into Suicide by People With Mental Illness (NCI) survey, and the Hospital Episode Statistics database, which collects de-identified data for the National Health Service (NHS) from inpatient admissions (Bickley et al., 2013). Clinicians were asked to complete a suicide questionnaire in relation to those who had committed suicide and those in the control group completed an identical questionnaire with the suicide date matching that of their discharge date (Bickley et al., 2013).

Of the 100 suicides that occurred hanging was noted to be the most common method of suicide, followed by self-poisoning, jumping from a height or in front of a vehicle, drowning and cutting or stabbing respectively (Bickley et al., 2013). In order of occurrence the most common primary diagnosis in the suicide cases was major affective disorder, personality disorder, adjustment disorder and schizophrenia, with a majority of these involving a secondary diagnosis of (most commonly) depressive illness (Bickley et al., 2013). Results from the study showed that within the first week after discharge from psychiatric care 55 suicides occurred, predominantly on the second day after discharge, with nearly half of those ending their lives before receiving any follow up care in the community (Bickley et al., 2013). Findings showed that those aged 40 and over were at greater risk for suicide, those who had died were most likely to have had an inpatient admission of less than a week, have had a self-harm history, a co-morbid psychiatric diagnosis, a recent onset of illness, be of male gender and recently experienced adverse life events (Bickley et al., 2013).

The results from Bickley et al.’s research also suggested that ‘enhanced aftercare’ for those who were already in receipt of community care was a protective factor and that post discharge care should reflect this by regarding the first week as a high risk time for the patient. The authors emphasize the importance in discharge planning of knowing the individuals social circumstances and ensuring face-to-face contact after discharge, which may also prove to be protective (Bickley et al., 2013).

**Suicide statistics**

Suicide is a global phenomenon around the world with over 800,000 people dying from it every year (World Health Organization, 2014). This equates to one death every 40 seconds and a global age-standardized suicide rate of 11.4 people per 100,000 population (WHO, 2014). This figure does not include those who attempted suicide, those affected by suicide or those who experienced suicide bereavement (WHO, 2014). Although suicide affects many age groups, in 2012 it was the second leading cause of death globally in the 15-29 year old age group (WHO, 2014). Statistics from 2012 show that suicide accounted for 1.4% of deaths worldwide, which
made it the 15th leading cause of death at that time (WHO, 2014). In terms of comparing New Zealand suicide rates to other OECD countries (both male and females rates), we are described as being in the ‘middle of the range’ (Ministry of Health, 2014). Unfortunately our youth suicide rates were the second-highest of the 33 countries listed with the only difference being that the data from New Zealand was from the year 2011 compared to that from 2010 from the other countries (Ministry of Health, 2014).

It is also interesting to note that in 2012, 75% of global suicides occurred in low and middle income countries (WHO, 2014), indicating to the author that socioeconomic influences play an important role in individuals choosing to end their life by suicide. It is worth considering at this point that socioeconomic factors can also influence the means of how people die, i.e. accessibility of firearms, availability of gases, and so on. There is also a tendency for women to choose less violent means, such as overdosing, and men more ‘masculine’ ways, such as using a firearm, and of course age plays a role in method choice. Documentation and studies show a definite link between suicide and psychiatric illness which is evidenced in many suicide notes and records left behind. Jamison (2000) and Weaver (2014) alike provide numerous examples in their books of the last words of many of those who have committed suicide who attempted to explain their reasons and internal suffering.

In New Zealand 478 people died by suicide during 2011 where 369 of these were male and 109 were female (Ministry of Health, 2014). From these statistics it is noted that the female rate has remained relatively stable since 1948 and that the figure of 478 equates to 10.6 deaths per 100,000 population (Ministry of Health, 2014). In 2011 the highest suicide rate occurred in the youth age group (15 – 24 years) which equated to 19.3 deaths per 100,000 being 93 males and 31 females (Ministry of Health, 2014). Suicide was the most common cause of death for this age group with motor vehicle accidents (86 deaths) being the second most common cause. The next highest age group was 25 – 44 (13.8 per 100,000), then 45 – 64 (13.2 per 100,000) followed by adults aged 65 and over with the lowest suicide rate of 7.3 per 100,000 people in this age group (Ministry of Health, 2014). In the same year there were 108 Maori suicides (16.8 per 100,000 Maori population), 9.1 non-Maori deaths per 100,000 along with 24 deaths in the Pacific group and 28 among Asian people (Ministry of Health, 2014). Deprivation also played a part in the 2011 suicide statistics for New Zealand where there were 14.0 deaths per 100,000 population in the most deprived areas and 8.4 deaths per 100,000 in the least deprived areas (Ministry of Health, 2014).

In the same publication the Ministry of Health (2014) list the number of intentional self-harm hospitalisations in 2011 as being a massive 2647 with the highest rate of cases affecting the 15 –
19 age group where 80.8 per 100,000 occurs in the male youth population and an incredible 212.0 in female youths. In the years since comparable data became available in 1948 the highest suicide rate for the whole population of New Zealand occurred in 1998 with 577 deaths (Ministry of Health, 2014). Despite having decreased by 29.8 percent by 2011 this figure still remains too high.

Ministry of Health (2014) report that the most common method of suicide in 2011 was hanging, strangulation and suffocation collectively, which applied to both males and females. The second most common cause was poisoning by solids and liquids for females and poisoning by gases and vapours for males (Ministry of Health, 2014). In New Zealand a death can only be classified as a suicide after an official coroner’s inquiry has been completed (Ministry of Health, 2014).

**Chapter summary**

The majority of studies reviewed have been undertaken overseas, therefore the results may or may not be relevant to New Zealand practice due to differences in health care systems, socioeconomic, political and cultural issues. The research included in the literature review was conducted or reviewed in Japan, England, Ireland, Scotland, North America, Europe, Canada, Australia and New Zealand. The two studies from New Zealand included one review of the literature in 1992 on staff response to inpatient and outpatient suicide to assist in establishing a ‘suicide audit’, and the other a qualitative study in 2004 of the impact on mental health nurses when a patient dies through suicide.

This review highlights the geographical and chronological gap in literature, specifically in New Zealand, justifying the need for this research. As mentioned, the chronological gap is apparent in the research by the age of some of the research articles (with one dating back as far as 1985), and how this can impact on a profession that relies on contemporary research. Another important aspect from the literature reviewed is that the majority of the research is conducted in either an inpatient or a community setting, where this research aims to consider both settings.

With the need for more research from a nursing perspective on the issue of suicide, although research on other health professionals is included, there are different roles, responsibilities and relationships involving patients between the professions that must be considered.

The second part of the research question and the literature review addresses the issue of support and what is needed. The literature indicates that there is a need for support however there appears to be no clear guidelines or postvention protocols on how best to provide and manage this. The next chapter discusses in detail the research design and method.
Chapter Three: Research Design and Method

In this chapter the research design and methodology are identified and discussed. A description of the measurement tool used in this study, to determine if there is a psychological impact on nurses who have experienced patient suicide, is provided. Ethics and data analysis are also discussed in this chapter including the sample, population, data collection and analysis methods.

Design

This research was conducted via an anonymous on-line survey appropriately suited to a quantitative design, taking into account the sensitive nature of the topic. This enabled the researcher to maintain distance and anonymity of potential study participants working within the same District Health Board. The majority of the available literature published in relation to a nurse’s perspective of patient suicide uses a qualitative approach. Therefore using a quantitative design required the use of a measurement tool that could produce numerical data to determine if a patient suicide had an impact on nurses. Jirojwong (2011) defines quantitative research as a scientific investigation method that requires quantifiable data about a phenomenon to answer a research question. In terms of qualitative versus quantitative research; qualitative can provide more in-depth data with minimal participants but can also be time consuming; quantitative research can involve a larger number of participants, produce numerical data that can be collected and analysed relatively easily (Jirojwong, 2011). This research aims to provide quantitative data for research purposes however also offers space for free text answers, allowing participants to share their experiences and insights into this topic, incorporating both quantitative and qualitative data.

Method

This research involved a quantitative descriptive study with a purposive (non-probability) sample (Schneider et al., 2007) of mental health nurses working within a specific District Health Board (DHB) that have experienced a patient suicide in their career. The link to the survey was emailed to individual DHB email addresses of all registered nurses working in the area of mental health within the DHB. This was initiated with the assistance of a senior nurse, who forwarded the link to all mental health service managers. The response rate was 16% (64 out of a potential 400 participants), and of those who responded only 58 (14%) were eligible to complete the survey due to the other six participants not having experienced a patient suicide.
The survey and data collection were done via Survey Monkey™ allowing distance and anonymity of participants from the researcher. Inclusion criteria required participants to be registered nurses working in mental health services within a specified DHB covering a large geographical region. To complete the survey participants were required to have experienced a patient suicide within their career. Consent was assumed by completion of the questionnaire. For the purpose of this thesis it was the intention to look only at the experiences of mental health nurses, not other health professions, to keep the study to a manageable size.

The questionnaire designed for the purpose of this study comprises 13 questions made up of demographic information for statistical purposes, questions relating to support received after a patient suicide along with space for further comment, concluding with the modified Impact of Event Scale-Revised (IES-R) for participants to complete. The questionnaire was pre-tested by three mental health nurses who had experience of a patient suicide and were not eligible to participate in the survey prior to the finalised version being distributed (Tolich & Davidson, 2011). Feedback from the pre-test resulted in the question ‘How many patient suicides have you experienced in your career?’ being altered to ‘How many patient suicides have you experienced either directly or indirectly in your career? (Please state number). The time frame to complete the survey was also reduced from ‘30 minutes’ to ‘20 minutes’ based on pre-testing feedback.

**Impact of Event Scale – Revised (IES-R)**

The original Impact of Event Scale (IES) was designed and published by Horowitz, Wilner and Alvarez (1979) as a self-report tool to measure the degree of subjective impact caused by a specific event. More specifically, it was designed to be applied to any event causing distress and the response level to that event over the past seven days (Weiss, 2007). The development of this tool involved two major response sets (intrusion and avoidance), which when answered provided numerical sub scores for each category as well as a total score for subjective stress (Horowitz et al., 1979). After being trialled over several years the IES was reduced from 20 items to 15 and was “frequently endorsed by a population seeking help for post-traumatic stress disorder” (Horowitz et al., 1979, p.217).

The literature provides a plethora of studies utilising the IES and documenting its worth as a measurement tool such as studies involving Vietnam War veterans, Israeli combat soldiers, survivors of natural disasters, accident situations, criminal victimisation, rape, sexual abuse and families of homicide, emergency service workers and life threatening medical conditions such as cancer (Weiss & Marmar, 1997).
Weiss (2007) further explains the in-depth process of translating the scale into numerous languages for the purpose of global traumatic events such as gas attacks, chemical explosions and in the case of SARS (Severe Acute Respiratory Syndrome). The scale has produced consistent findings with the ability to provide documentation on responses to life events while also assisting in predicting future distress and changes in response to traumatic exposures (Weiss & Marmar, 1997). The literature provides evidence of the usefulness of the IES as an outcome measure along with the validity and reliability of the tool from a psychological perspective in response to a traumatic event (Weiss & Marmar, 1997).

Weiss and Marmar (1997) note that the IES predated the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) published by the American Psychiatric Association and the adoption of the term ‘Post Traumatic Stress Disorder’ (PTSD) in the nomenclature. They even go so far as to suggest that data gathered by this tool could have indeed set a precedent for the diagnostic entity of PTSD in this globally recognised publication.

The Impact of Event Scale was revised in 1997 by Daniel S. Weiss and Charles R. Marmar. To improve the scale further, hyperarousal symptoms were included as they were deemed to be an integral part of the psychological response to traumatic events, and part of the (then DSM-III and now) DSM-IV diagnostic criteria (Weiss & Marmar, 1997; Weiss, 2007). It is now known as the Impact of Event Scale – Revised (IES-R) and consists of 22 questions relating to the impact of a stressful life event. The revision of the scale meant that seven additional items were added; six within the hyperarousal domain and one to the intrusion subscale. Predominantly the intrusion and avoidance subscales remain the same as they were in the original IES except for the modification of the item “I had trouble falling asleep or staying asleep” (Weiss & Marmar, 1997). This item was separated into two; falling asleep (hyperarousal domain) and staying asleep (intrusion domain) with the latter addressing flashback-like re-experiences (Weiss & Marmar, 1997). The six new hyperarousal items addressed hypervigilance, psychophysiological arousal with exposure to reminders, difficulty concentrating, exaggerated startle response and jumpiness, and irritability and anger (Weiss & Marmar, 1997).

The recommendations of Weiss and Marmar (1997) at this time were that participants be asked to report the degree of distress (of symptom) over the past seven days rather than the frequency of the symptoms (Weiss, 2007). They also suggested that the response format be modified to a ‘0-1-2-3-4’ rating with equal intervals, as opposed to the pre-existing version designed and adopted by Horowitz et al. (1979) that had unequal numerical intervals (Weiss & Marmar, 1997, Weiss, 2007).
The IES-R was designed to look at levels of distress over a seven day period however I have modified the scale to relate to the ‘most distressing patient suicide’ that a mental health nurse has experienced in his/her career. Horowitz et al. (1979, p. 218) endorsed the use of the original IES long term by stating:

Clinicians have found the Impact of Event Scale useful in following the trajectory of a person responding to a specific traumatic life event over a long period of time, since it can easily be used repetitively and anchored to the same psychological trauma over the entire time span.

The tool itself is widely and readily available on the internet however its reliability and validity have been proven over the years and are well documented. It is predominantly used as a screening tool for those who are potentially suffering from PTSD (Horowitz et al., 1979).

**Posttraumatic Stress Disorder**

The diagnostic criteria for Posttraumatic Stress Disorder is;

A. The person has been exposed to a traumatic event in which both of the following were present:

   (1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.

   (2) the person’s response involved intense fear, helplessness, or horror. Note: In children, this may be expressed instead by disorganized or agitated behavior.


The term ‘Posttraumatic Stress Disorder’ (PTSD) was introduced into the psychiatric literature in 1978 when the International Classification of Diseases, Ninth Revision (ICD-9) was published (Weiss, 2007). The ICD-9 (current version is ICD-10) gathers, processes, classifies and presents mortality statistics and allows for international comparability and recognised typical symptomatic responses to traumatic life events (Weiss, 2007). The Diagnostic and Statistical Manual of Mental Disorders - Fourth Edition (DSM-IV) is also a classification system for mental disorders and is the current tool used in New Zealand, whereas the ICD-9 is used more globally.
PTSD is defined by the American Psychiatric Association (APA) diagnostic criteria as being the exposure to an actual or threatened death, serious injury or sexual violation (APA, 2013). To meet the criteria the event must be shown to cause clinically significant impairment or distress to an individual’s social and work environments along with other areas of general functioning (with symptoms continuing for more than a month), however it must not be the result of drugs, alcohol, medication or another medical condition (APA, 2013).

There have been changes from the previous version of the DSM-IV to the current edition (DSM-V), which now sees PTSD classified as a ‘Trauma- and Stress-or-Related Disorder’ rather than an anxiety disorder (APA, 2013). The focus in the DSM-V is on the accompanying behavioural symptoms and includes the four diagnostic clusters described as negative cognitions and mood, re-experiencing, avoidance and arousal, encompassing both the ‘fight’ and ‘flight’ aspects of the event (APA, 2013). This study has continued to use the DSM-IV as there have been no studies done to date determining the reliability and validity of the IES-R in conjunction with the DSM-V.

Olszewski and Varrasse’s (2005) article investigated the neurobiology of PTSD and the implications for nurses. It is important to consider that not all those exposed to trauma will develop symptoms of PTSD and that sometimes the onset of symptoms can appear years after the event occurred, and last a lifetime (Olszewski & Varrasse, 2005). The pathophysiology of PTSD involves a complex system of activity and dysregulation of neurotransmitters within the brain which has a direct correlation on how it processes information about traumatic memory (Olszewski & Varrasse, 2005). It is also worth noting that the physiological and biological dimensions of PTSD are driven by intrusive memories of the event more so than the direct experience of it (Olszewski & Varrasse, 2005).

Olszewski and Varrasse (2005) describe PTSD as a ‘complex anxiety disorder’ requiring a therapeutic approach to treat it, with the suggestions of psychotherapy, peer support, group therapy and medication as possible treatment options. This information is useful to consider in relation to nurses themselves experiencing a traumatic event, such as a patient suicide, and the impact and long term effects if the incident is not adequately addressed at the time.

The questionnaire developed specifically for this research comprises 13 questions beginning with demographic information; age, gender, years working as a Registered Nurse (questions one to three), then participants were asked if they had experienced a patient suicide and if so how many suicides they had experienced during their career (questions four and five). Participants were then asked to consider the most distressing suicide they had experienced in their career,
while working in New Zealand, and clarify whether this occurred in an inpatient or community setting (question six). Questions seven through to 12 focussed on support after the event; was any support offered, if so what was it, what was most beneficial, least helpful, what could have been useful and space was provided for further comment on the topic. Question 13 was the Impact of Event Scale – Revised (IES-R) which participants completed by rating each of the 22 questions in the scale with ‘not at all’ (0), ‘a little bit’ (1), ‘moderately’ (2), ‘quite a bit’ (3), or ‘extremely’ (4), providing a numerical score between 0 – 88 for each participant (Weis & Marmar, 1997).

The purpose of the demographic data is to provide specific details about the participant group and to determine the length of their nursing career. The author believed the demographic information would be important as a starting point for comparison in potential future research in this area. Inclusion criteria required that a nurse had to have experienced a patient suicide, so question four determined if they were eligible to continue with the survey. If so, they were asked to recall how many suicides they had experienced, potentially correlating to how many years they had been practising, i.e. the more years worked, the more suicides experienced. Question six was predominantly to determine whether the nurses most distressing suicide occurred in an inpatient or community setting (as much of the available literature relating to nurses examines inpatient or community) however it also clarified that their experience had to have been in New Zealand, as the purpose of this study is to benefit New Zealand research. Participants were also asked to recall and focus on the most distressing suicide they had experienced in their careers from question six onwards, for some participants this could have occurred some time ago. The relevance of retrieving information relates to the IES-R, which was designed to be utilised seven days after an event, however considering the logistics and timeframe required for this research, this was not possible for the researcher to attempt.

The questions around support after a patient suicide were designed to establish if any support had been offered to participants, answered with a ‘yes/no’ answer. If support was offered, participants were asked to specify what that support was. This was expanded further by asking what support had been the most beneficial, least helpful and what could have been useful, (questions nine, 10 and 11) and were based on Joyce and Wallbridge’s (2003) research to determine the use of staff resources and support. The purpose of having a space for participants to comment was to meet the final objective of this research; ‘to gain any further knowledge from nurses who have experienced a patient suicide to help educate and empower others.’ Polit and Beck (2010) describe qualitative research as the investigation of a phenomenon using a flexible research design gained by collecting rich narrative material from holistic and in-depth questioning. The purpose of analysing this data is to organise and interpret it producing patterns,
categories or themes that are often underlying in material collected (Polit & Beck, 2010). A qualitative approach using the free text answers in this survey allowed participants to describe and explain in their own words what was helpful for them, producing themes relevant to their experiences. This method also ensures that the themes initiate from the participants themselves rather than agreeing or disagreeing with the researchers ideas of what was helpful or not.

Utilising the Impact of Event Scale – Revised (IES-R) produces quantitative data that can be directly related to symptoms of Posttraumatic Stress Disorder (PTSD), indicating the presence of an emotional and/or psychological impact on mental health nurses who have experienced a patient die by suicide. Takahashi et al.’s (2011) research incorporated the IES-R stating participants scoring 25 or more on the 88-point scale were defined as being in a group at high risk of developing PTSD. Takahashi et al. (2011) linked the IES-R to PTSD saying that nurses who lose a patient to suicide can feel responsible, with the ensuing feelings of guilt and self-condemnation potentially resulting in depression and other symptoms of PTSD, affecting their professional identity and nursing practice.

**Ethical considerations**

Ethics approval was sought and granted by Eastern Institute of Technology (EIT) Research Ethics and Approval Committee (REAC) Chair. This was determined after completing the EIT ‘Low Risk Research Questionnaire’ with the recommendation of EIT approval and completion of the RAD Form. The Health and Disability Ethics Committees (HDEC) flow chart indicates that HDEC approval was not required. The regions locality approval was sought and approved, with DHB site approval incorporated into this.

Survey distribution was via a direct link to Survey Monkey™ provided to a senior nurse within the DHB, which was emailed to mental health services managers, then forwarded onto Registered Nurses under their management. No funding was sought for this research.

**Cultural consideration**

The Unit Manager of the local Maori Mental Health Team was contacted by the researcher to ascertain any specific cultural concerns around this research topic. The only suggestion offered was to ensure participants were made aware of support available in the event issues arose from completing the survey. Contact details were provided on the participant information sheet accompanying the survey.
Data analysis

Data analysis using descriptive statistics allows data to be organised and interpreted into meaningful and manageable units (Schneider et al., 2007). Data analysis and storage was undertaken with the use of Survey Monkey™ which has this functionality and a password protected computer. The quantitative data from this study is presented in colour coded pie graphs produced by Survey Monkey™. Thematic analysis was utilised to examine the qualitative information provided by the free text answers for regular recurring themes. Raw data (participants own words), are included to support and provide more detailed descriptions of thematic analysis (Polit & Beck, 2010).

Thematic analysis is described by Braun and Clarke (2006) as being a useful measurement tool that has the ability to produce a rich, detailed account of data while providing flexibility through its theoretical freedom. Predominantly this method identifies, analyses and reports themes from the data in rich detail, with a level of organisation that often goes further to interpret aspects of the topic (Braun & Clarke, 2006). The researcher believes the idea which Braun and Clarke (2006) put forward about thematic analysis reflecting ‘reality’, with the potential to being able to unpick/unravel this reality, relates to the personal experience of an individual and how they perceive this. By incorporating space for free text answers in this survey, participants were provided the opportunity to relate their own experience of patient suicide and what intervention had ensured a positive way forward for them after the loss.

“A theme captures something important about the data in relation to the research question, and represents some level of patterned response or meaning within the data set” (Braun & Clarke, 2006, p. 82). The correlation between participant’s answers and themes requires a level of judgement by the researcher, which Braun and Clarke (2006) state is necessary, while remaining flexible and not adhering to rigid rules. Braun and Clarke (2006) also reiterate the topic of prevalence in relation to what counts as a theme, as there are no hard and fast rules around this, researcher judgement and consistency are highlighted here.

Thematic analysis of the results from this survey provided by the free text answers (in relation to support after a patient suicide), followed the ‘6 step guide’ suggested by Braun & Clarke (2006);

Phase 1. Familiarizing yourself with your data.

Individual responses from free text answers exported from Survey Monkey™ were printed then read and re-read. Using Schneider et al.’s (2007) analysis style of ‘circling and parking’, the
data set as a whole was considered; this was ‘circled’ around and ‘parked’ at times for closer scrutiny of some data. This cycle continued until such time as ‘meaning was made’ of the data allowing the completion of the process leading into the next phase.

*Phase 2. Generating initial codes.*

Coding was done manually by the researcher, using coloured highlighters, indicating potential patterns based on the data provided and grouped together, such as ‘peer support’ and ‘clinical supervision’. This process was repeated for each of the questions around support.


The colour coded information was then combined into themes using a thematic map for each question about support i.e. support offered, beneficial support, least helpful support and useful support (questions 8, 9,10, 11 respectively). This produced themes of; informal debriefing, clinical supervision, managerial/leadership support, EAP, formal debriefing and peer support.

*Phase 4. Reviewing themes.*

At this phase of reviewing the themes a coherent pattern began to form combining existing themes into three overarching themes of; support from colleagues and management, informal and formal debriefing sessions and support from other sources being EAP and clinical supervision.

*Phase 5. Defining and naming themes.*

The themes were then named and defined as; ‘Collegial support’ (combining peer and management/leadership support) indicating that support came from within the work environment by peers and managers. The second theme of ‘Debriefing’ combined both formal and informal sessions, where support came from a wider group of people from within and outside the work environment. The third and final theme was titled ‘Other’ and encompassed EAP and Clinical Supervision, provided by those outside of the work environment.

*Phase 6. Producing the report.*

The results from this analysis are recorded in Chapter Four (Findings) of this study and are discussed more fully in Chapter Five (Discussion). The results produced by each of the individual questions are documented in order of most prevalent. Each of the three themes identified from the survey results by thematic analysis is supported with raw data provided by participants.

In terms of ‘trustworthiness’ of the qualitative research incorporated into this study, supervisor feedback has provided the researcher with appropriate guidance and support around documentation of the findings. The researcher’s primary supervisor has also had access to the raw data provided by this study, ensuring further trustworthiness of the data and research outcomes.
Chapter summary

This chapter has provided an explanation of the methodology utilised as well as justification for this study. A description of the measurement tool has been provided, supported by documented evidence of its reliability and validity, and correlation with PTSD symptomology. The questionnaire and its purpose have been explained in detail along with information regarding ethical and cultural considerations provided. A summary of data analysis concludes this chapter before the findings of the study are examined in the next chapter.
Chapter Four: Findings

Chapter three described the design, method and analysis of the research. This chapter reports on the findings from the anonymous on-line survey. Quantitative data is presented in graphs as percentages, analysed by Survey Monkey™, and free text answers are grouped into common themes and supported by participant’s responses.

It is relevant to note here that the majority of this study was done using a quantitative approach, with space for free text answers, whereas many of the studies based on nurse’s experiences have used a qualitative method. A quantitative method was utilised for this research to maintain anonymity of participants as the researcher works in the same District Health Board the study was conducted in, having potentially experienced the same patient suicides, therefore eliminating any researcher bias.

From a potential 400 participants 64 responses were received with only 58 of these nurses having experienced a patient suicide. The first three questions of the questionnaire were designed to gather demographic information and question four was ‘Have you experienced a patient suicide?’ at which point six participants responded with ‘no’ and exited the survey.

![Pie chart showing the experience of patient suicide](image)

**Figure 1. Experience of patient suicide**

Inclusion criteria required participants to be Registered Nurses that had experienced a patient suicide, six of the initial 64 respondents answered ‘no’ to this question, leaving only 58 participants who were suitable to complete the survey.
Of the 58 eligible respondents 43% (n=25) were aged between 50 - 59, 24% (n=14) were in the 40 – 49 age group, 12% (n=7) were 31 - 39 years old, followed by 14% (n=8) who were 60 – 64 years of age. Only 2% (n=1) of respondents were aged 30 or under, with 5% (n=3) in the 65+ age group.

Of the 58 respondents 78% (N=45) were female and 22% (N=13) were male.

Years working as a Registered Nurse varied from four up to 42 years, with 32 (55%) of the participants employed in this role for 20 years or more. One participant chose not to answer this question, while one stated they worked as a Registered Nurse in a management role and two identified they had also worked as Enrolled Nurses.

The number of patient suicides experienced by the 58 participants, either directly or indirectly, ranged from one to 30 with one that was answered “how indirectly do you mean?” and one that stated “quite a number”.

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Although not analysed in any depth, there could potentially be a correlation between length of years working as a registered nurse and number of patient suicides experienced. The 50 - 59 age group consisted of the most participants (19 females and six males), where two of these nurses had worked less than ten years as a registered nurse and 23 had worked for more than ten years. Of these 25 (43%) participants, 18 (31%) had experienced less than ten patient suicides in their career and six (10%) had experienced more than ten. This would require further investigation as information on the numbers of suicides experienced were not always exact e.g. 12+.

Figure 4. Inpatient or community setting

When asked to consider the most distressing suicide experienced during their career in New Zealand and what setting they were working in at the time, 53% (N=31) answered community setting while the other 47% (N=27) answered in-patient.
Question 7 of the survey was about ascertaining whether any kind of support had been offered after the event, which 84% (N=49) of respondents answered ‘yes’ to and the remaining 16% (N=9) answered ‘no’.

Qualitative data from free text responses

Following on from the previous question, participants were specifically asked what support they were offered, which often consisted of more than one intervention. Using a thematic analysis approach three common themes of support emerged; collegial support (peer and management/leadership support), debriefing (informal and formal) and other (Employee Assistance Programme and Clinical Supervision).

Collegial support (peer and management/leadership support)

From the 58 respondents who took part in this survey, collegial support was the most offered form of support after a patient suicide at 65% (n=38). This theme was clearly divided into two different aspects; peer support at 43% (n=25) and managerial/leadership support at 22% (n=13). Informal peer support, staff/collegial support and support from other team members were recognised as being important with one participant responding with;

A friendly colleague spoke with me, someone drove me home
Another stated;

*Colleagues were very supportive and encouraging*

The managerial/leadership support theme lacked a clear definition of what was being offered at times; described as leadership support, direct manager support, support from management, a supportive talk from line manager, management offered time off work or summed up as just good support from manager. Others however were very clear and definitive about what support they were offered;

*Our managers met with us briefly immediately after the event and again a few days later*

*Duties covered to facilitate time to process, attend funeral etc*

*Email from manager offering more support if wanted*

*Regular support with senior staff to discuss the event*

**Debriefing (formal and informal)**

Debriefing was another recurrent theme of support offered to mental health nurses after a patient suicide at 47% (*n*=27). In some instances it was not always clear from the respondent’s answers whether the debriefing offered was formal or informal and was often described as staff debrief, debriefing session, debrief held on ward, support from the employer to have debriefing, and one participant who reported having had one debrief that was poorly carried out. One respondent spoke of an informal debriefing with the immediate line manager, as well as those respondents that clearly articulated formal and informal support;

*Full debriefing and follow-up support offered*

*Informal immediate support/debrief with staff on duty at the time. Formal debrief organised within 2 weeks*
Other (EAP and Clinical Supervision)

Employee Assistance Programme (EAP)
This support was predominantly referred to as ‘EAP’ or alternatively ‘Vitae’. Vitae is a nationwide service provider comprised of professional clinicians trained in the many areas of providing assistance to employees with a wide range of workplace and personal issues. Due to the nature of the health organisation they provide a confidential counselling service off-site and accept self-referrals as well as providing a 24 hour Freephone number. Responses showed that 33% of participants (n=19) had been offered EAP as a form of support.

Clinical supervision
Te Pou (2015), the national centre for evidence based workforce development for mental health, addiction and disability sectors in New Zealand, defines clinical supervision as being “Focused on developing a person’s clinical role and practice with a focus on quality control, assessment of the person’s knowledge, roles, attitudes, beliefs and skills.” Ideally clinical supervision is available to all nurses in New Zealand working within the mental health and addiction workforce on a regular and consistent basis to improve clinical practice, job satisfaction, and to decrease stress and burnout (Te Pou, 2013). Responses showed that 19% of participants (n=11) had been offered clinical supervision as a form of support.

Beneficial support
Once it had been established who had been offered support and what that support consisted of, the next goal was to determine what support the participants found most beneficial after the suicide. The answer to this question was clearly dominated by collegial support at 71% (n=41), both immediate and on-going where respondents described informal support from colleagues, peer support, team support, support from fellow staff members and talking with other colleagues about the event. Also mentioned in this theme was support received from a direct manager, informal debriefing with immediate line manager and a combination of both collegial and managerial support while also being offered time off. Participants found the most beneficial support was that which was offered by colleagues involved in the incident or who had had previous experience with a patient suicide, and is evidenced by the following answers;

- The support we gave each other (those involved) was most beneficial
- Support of my colleagues who were also affected by the experience
The informal immediate support – gave all staff involved the ability to discuss openly what had occurred/feelings/thoughts

Work mates – particularly those who had experienced what I was experiencing

Least helpful support

Participants identified the debrief session as being the least helpful intervention after a patient suicide being 21% (n=12). Participant’s responses to this question indicate why they believed debriefing to be the least helpful and explain their feelings around this;

The one debrief I attended people were invited that were not involved in the event. I felt it was more a session for others to find out what happened more than a debrief session.

Found the debriefing very confrontational and intimidating

Debriefing meeting was overwhelming and feelings seemed to be minimised

Having people attend the debrief who have no patient involvement and comments such as “they are at peace now” when the event has only just happened

Debrief was too late after event

Debrief Team was too soon after actual suicide for any personal processing to have occurred

Debriefing. The timing wasn’t right for me. By the time de-briefing came up I had already addressed and talked through many of the issues I had with colleagues I trusted and valued the opinions of. I felt de-briefing actually just exposed me to other peoples still quite raw emotions which I was no-longer feeling and it just raised my anxiety again. The group was too big and conversation was taken over by a small group of very vocal individuals. I struggled with the sense that some (whom I had no real relationship with) were trying to absolve themselves of blame or apportion blame elsewhere which was challenged by the facilitators but once an idea is raised it can’t be un-raised. It was made very clear that attending debriefing was not optional on this occasion.
For 12% of participants (n=7) managerial support was another aspect that was seen as not being helpful due to feelings that management were more concerned with the risk of litigation and protecting the organisation than the nurses. The style of support from management was deemed unhelpful, as was the response that management were unsupportive and could have offered more assistance during this traumatic time, however neither participant offered any further explanation. One respondent experience was ‘summed up’ as;

*Support from senior managers, felt very forced and superficial. Appeared that the prime objective from senior managers was about protecting the organization*

Two respondents reported the following examples as being unhelpful;

*Senior management offering support by shouting the whole ward (staff and consumers) pizza hut for tea that evening and then the following evening with Indian take out. Management – they provided pizza for patient’s tea that night – HELLO!!*

Other interventions that respondents found unhelpful were how information was delivered to them, a New Zealand Nurses Organisation support person who was unprepared for interviews relating to the investigation, EAP and ‘at work support’ (indicated that ‘out of work’ support was more useful, such as family and church), each having two responses for each intervention. There were also a few participants (14%) who were unsure or found nothing unhelpful (n=8) and 10% who believe that ‘all support is helpful or good’ (n=6).

**Useful support**

When respondents were asked what support they thought would have been useful in this situation, it is perhaps best summarised as ‘what the nurse needs’ in terms of their personal grieving, which was rated at 21% (n=12), based on an acknowledgment that staff go through a grief process. Interventions of impromptu/informal peer review and debriefing along with time management, support and education were mentioned as being useful. Other suggestions included a more appropriately timed debrief with only those involved in the event at14% (n=8), nothing additional at 12% (n=7), clinical supervision at 7% (n=4) and follow up debriefing also at 7% (n=4). Individual reflections on the process and the events following a patient suicide
allowed some participants to define exactly what they would have found useful based on their own personal experiences, comments include;

To be able to deal with the situation as I needed to, to have the space for at least that day to come and go, talk with colleagues or have alone time

And

As a team we were given the opportunity to ask for what we needed. We were able to also seek personal counselling if needed

I think it would have been helpful to be listened to regarding roster request changes and some support when going back to nightshift and being the only senior nurse on the ward and in charge when was feeling rather vulnerable

Perhaps some time off to gather myself and re-affirm how or if I wanted to continue in my work. Not sure if this would be helpful but would be nice if it was offered to you and that it didn’t reduce your holidays or sick days

Comments

The last space for free text answers prior to participants being asked to complete the IES-R was for comments relating to support, or their experience of patient suicide in general. Although not everyone chose to comment, following are a few that the researcher deemed potentially helpful to those finding themselves in a similar situation;

Just to increase own self awareness

Everyone is different and every suicide may evoke a different response, so I don’t think there is any best approach to what is offered

I think the major thing is to be working in an environment where the impact is understood and not treated as “something to get over”. In that respect I have been fortunate

I have wondered what type of tolerance this type of repeated experience has induced in me, but I always reason that it is all part of coping with human tragedy
I believe that some people may have a belief that suicides are a risk involved with working in the field of mental health however the impact on ones own mental health well being following a suicide is not always investigated/considered

In my opinion, individual members of staff will respond in different ways to individual suicides and the circumstances of each. Each clinician is unique; each client is unique; each suicide is unique

One respondent also said that they found informal/impromptu peer supervision and support the most suited to their needs and that group debriefing was not helpful for them. The next point they made was in reference to the fear of liability and “scapegoating” in relation to apportioning blame, finishing with the following exert;

Secondly I am concerned and have a conscience about whether I have done the right things, or whether I could have performed better for the deceased. On this second point I am my own judge and jury; and my own worst critic. I suspect my colleagues and peers feel the same way, and in this regard I have received my most important support and understanding from them

Findings from the Impact of Event Scale – Revised (IES-R)

Initial analysis of the data showed that of the three subscales that make up the categories in the IES-R; avoidance, intrusion and hyperarousal, there was a definite impact in the intrusion section of the scale.

The scoring method is based on a ‘Likert Scale’ (Tolich & Davidson, 2011) where each of the 22 questions is scored as follows;

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Not at all</td>
</tr>
<tr>
<td>1</td>
<td>A little bit</td>
</tr>
<tr>
<td>2</td>
<td>Moderately</td>
</tr>
<tr>
<td>3</td>
<td>Quite a bit</td>
</tr>
<tr>
<td>4</td>
<td>Extremely</td>
</tr>
</tbody>
</table>

Avoidance Subscale consists of questions; 5, 7, 8, 11, 12, 13, 17, 22
Intrusion Subscale consists of questions; 1, 2, 3, 6, 9, 14, 16, 20
Hyperarousal Subscale consists of questions; 4, 10, 15, 18, 19, 21

The table and graph following show the results from the completed IES-R in this study;
<table>
<thead>
<tr>
<th>True Feelings</th>
<th>Not at all</th>
<th>A little bit</th>
<th>Moderately</th>
<th>Quite a bit</th>
<th>Extremely</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any reminder brought back feelings about it</td>
<td>6.50%</td>
<td>20.69%</td>
<td>31.03%</td>
<td>37.93%</td>
<td>3.45%</td>
<td>56</td>
</tr>
<tr>
<td>I had trouble staying asleep</td>
<td>32.76%</td>
<td>37.93%</td>
<td>10.34%</td>
<td>13.75%</td>
<td>5.17%</td>
<td>58</td>
</tr>
<tr>
<td>Other things kept making me think about it</td>
<td>10.34%</td>
<td>41.38%</td>
<td>27.59%</td>
<td>20.69%</td>
<td>0.80%</td>
<td>58</td>
</tr>
<tr>
<td>I felt irritable and angry</td>
<td>37.03%</td>
<td>31.03%</td>
<td>18.97%</td>
<td>10.34%</td>
<td>1.72%</td>
<td>58</td>
</tr>
<tr>
<td>I avoided letting myself get upset when I thought about it or was reminded of it</td>
<td>25.31%</td>
<td>29.31%</td>
<td>24.14%</td>
<td>13.75%</td>
<td>3.45%</td>
<td>56</td>
</tr>
<tr>
<td>I thought about it when I didn’t mean to</td>
<td>13.79%</td>
<td>37.93%</td>
<td>25.86%</td>
<td>22.41%</td>
<td>0.80%</td>
<td>58</td>
</tr>
<tr>
<td>I felt as if it hadn’t happened or wasn’t real</td>
<td>70.18%</td>
<td>14.04%</td>
<td>5.26%</td>
<td>3.77%</td>
<td>1.75%</td>
<td>58</td>
</tr>
<tr>
<td>I stayed away from reminders about it</td>
<td>54.72%</td>
<td>34.48%</td>
<td>5.47%</td>
<td>6.90%</td>
<td>1.72%</td>
<td>58</td>
</tr>
<tr>
<td>Pictures about it popped into my mind</td>
<td>24.14%</td>
<td>31.03%</td>
<td>25.86%</td>
<td>12.07%</td>
<td>6.30%</td>
<td>58</td>
</tr>
<tr>
<td>I was jumpy and easily startled</td>
<td>65.52%</td>
<td>15.52%</td>
<td>8.62%</td>
<td>10.34%</td>
<td>0.80%</td>
<td>58</td>
</tr>
<tr>
<td>I tried not to think about it</td>
<td>37.93%</td>
<td>25.86%</td>
<td>18.97%</td>
<td>15.52%</td>
<td>1.72%</td>
<td>58</td>
</tr>
<tr>
<td>I was aware that I still had a lot of feelings about it, but I didn’t deal with them</td>
<td>54.72%</td>
<td>24.14%</td>
<td>18.97%</td>
<td>5.47%</td>
<td>0.80%</td>
<td>58</td>
</tr>
<tr>
<td>My feelings about it were kind of numb</td>
<td>47.37%</td>
<td>33.33%</td>
<td>12.28%</td>
<td>5.26%</td>
<td>1.75%</td>
<td>58</td>
</tr>
<tr>
<td>I found myself acting as though I was back at that time</td>
<td>85.56%</td>
<td>8.77%</td>
<td>3.51%</td>
<td>1.75%</td>
<td>0.80%</td>
<td>57</td>
</tr>
<tr>
<td>I had trouble falling asleep</td>
<td>47.37%</td>
<td>33.33%</td>
<td>7.07%</td>
<td>3.77%</td>
<td>3.51%</td>
<td>57</td>
</tr>
<tr>
<td>I had waves of strong feelings about it</td>
<td>26.32%</td>
<td>38.60%</td>
<td>26.32%</td>
<td>5.26%</td>
<td>3.51%</td>
<td>57</td>
</tr>
<tr>
<td>I tried to remove it from my memory</td>
<td>57.69%</td>
<td>26.32%</td>
<td>14.04%</td>
<td>1.75%</td>
<td>0.80%</td>
<td>57</td>
</tr>
<tr>
<td>I had trouble concentrating</td>
<td>52.63%</td>
<td>29.82%</td>
<td>12.28%</td>
<td>3.51%</td>
<td>1.75%</td>
<td>57</td>
</tr>
<tr>
<td>Reminders of it caused me to have physical reactions, such as sweating, trouble breathing or a pounding heart</td>
<td>75.44%</td>
<td>10.53%</td>
<td>8.77%</td>
<td>5.26%</td>
<td>0.80%</td>
<td>57</td>
</tr>
<tr>
<td>I had dreams about it</td>
<td>62.67%</td>
<td>24.14%</td>
<td>8.62%</td>
<td>6.17%</td>
<td>0.80%</td>
<td>58</td>
</tr>
<tr>
<td>I felt watchful or on-guard</td>
<td>48.28%</td>
<td>22.41%</td>
<td>17.24%</td>
<td>10.34%</td>
<td>1.72%</td>
<td>58</td>
</tr>
<tr>
<td>I tried not to talk about it</td>
<td>60.34%</td>
<td>22.41%</td>
<td>10.34%</td>
<td>5.17%</td>
<td>1.72%</td>
<td>58</td>
</tr>
</tbody>
</table>
Avoidance subscale: 29% (N=17) of the respondents answered ‘not at all’ and 29% (N=17) answered ‘a little bit’ to the statement;

*I avoided letting myself get upset when I thought about it or was reminded of it.*

Aside from this question all others in this section were answered with ‘not at all’.
**Intrusion subscale:** the following statement was answered with ‘quite a bit’;

*Any reminder brought back feelings about it*

Those answered with ‘a little bit’ were;

- I had trouble staying asleep 38% (n=22)
- Other things kept making me think about it 41% (n=24)
- I thought about it when I didn’t mean to 38% (n=22)
- Pictures about it popped into my mind 31% (n=18)
- I had waves of strong feelings about it 38% (n=22)

Those answered ‘not at all’;

- I found myself acting as though I was back at that time
- I had dreams about it

**Hyperarousal subscale:** all questions were answered ‘not at all’.

Participants completing the IES-R can score between 0 – 88 points (22 questions with a ‘0 – 4’ rating scale) that can provide a measure of the severity of PTSD symptoms, directly correlated to diagnostic criteria in the DSM-IV. Research (as cited in Takahashi et al., 2011) using the IES-R scale indicates that those scoring 25 points or higher are potentially at a higher risk of developing PTSD than those scoring less. Of the 58 respondents who completed the IES-R for this research, 22 out of 58 respondents (38%) scored between 26 and 58 on the scale. This information was gained by the author manually adding up the IES-R score for each individual participant then totalling how many scored more than 25 points.

**Chapter summary**

This chapter provides the results from the study using pie graphs to show percentages of; experience of patient suicide, age, gender, inpatient or community setting, and those who were offered support after the event. Three themes emerged from the data provided by the free text answers around support which were; collegial support, debriefing and ‘other’ support. These themes along with beneficial support, least helpful support, useful support and comments in general were supported with participants own words. This chapter concludes with the results from the IES-R scale. The next chapter incorporates the findings from this study and compares it to the literature.
Chapter Five: Discussion

This chapter provides a discussion on information obtained from the study, highlighting key issues relating to the literature to determine if there is indeed an impact on mental health nurses when a patient dies by suicide. Support will also be discussed in this chapter, outlining what others found helpful post suicide. Other considerations are also included in this chapter.

Participants completing the questionnaire for this study were asked to think back to the most distressing suicide they had experienced in their career in mental health nursing while working in New Zealand. It must be taken into account that this could have been a considerable amount of time ago based on the fact that participants had a career span of between 4 and 42 years. The other consideration here is that 32 of the 58 eligible respondents (55%) had been working in this role for 20 years or more and retrospectively the impact of the event could have diminished over time. As Farrington (1995) pointed out when discussing the benefit of debriefing being utilised within days of an event occurring, the longer the time lapse the more memory recall can be affected. It should also be noted at this point that the IES-R was designed to measure the impact of a stressful event over the ‘last 7 days’ and to determine a true impact on mental health nurses this would need to be carried out a week after the event occurred rather than retrospectively (Weiss & Marmar, 1997).

The total number of participants who logged into the anonymous on-line survey was 64; with 6 not having experienced a patient suicide, only 58 were eligible to complete the survey. The main age group was 50 – 59 (n=25), with the majority being female nurses (n =45). Considering the most distressing suicide experienced during a career in New Zealand, 27 of the respondents (47%) were working in an inpatient setting at the time and 31 (53%) were employed in a community setting. Interestingly, the majority of participants were able to state exact numbers of suicides they had directly or indirectly been involved with, suggesting that the memory of the events had remained with them. Support after the event of a patient suicide had been offered to 49 participants (84%), with 9 participants (16%) stating they had not been offered any kind of support.

Another factor that requires consideration for future research is gender differences. Of the 58 eligible nurses who responded to the survey 45 (78%) were female and 13 (22%) were male, however this has not been identified in the findings, and responses were not separated into male versus female but seen as a whole cohort. Gender differences could indeed show a potential impact on how patient suicide affects mental health nurses, especially considering nursing is
predominantly a female profession, however it not been addressed within the realm of this study.

**Offers of support**

Support offered to participants after a patient suicide was categorised into three different concepts, using a thematic analysis approach, consisting of collegial support (peer and management/leadership support), debriefing (informal and formal) and other (EAP and Clinical Supervision). Participants were predominantly offered more than one form of support.

**Offer of collegial support**

Collegial support was the most offered form of support; where peer support far outweighed management/leadership support, with the latter lacking a clear definition of what the support offered entailed such as;

*Direct manager support*

And

*Support from management*

From the responses, 25 participants (43%) were offered peer support and 13 (22%) were offered management/leadership support.

**Offer of debriefing**

Debriefing was another reoccurring theme however it was not always indicative from the respondent’s answers whether this was in a formal or informal manner. Responses that reiterate this are;

*Staff debrief*

And

*Debriefing session*

From the responses 27 participants (47%) indicated that debriefing, as a form of support, was offered to them after the death of a patient by suicide.
Other offers of support

The ‘other’ category is comprised of an Employee Assistance Programme (EAP) which is available to all the employees of the District Health Board and Clinical Supervision which is available to all mental health nurses working within the District Health Board. Responses showed that 30 of the participants (51%) were offered support from this category; 19 (33%) were offered EAP after a patient suicide and 11 (19%) were offered Clinical Supervision.

To clarify what clinical supervision is, McKenna, Thom, Howard and Williams (2010) describe it as a professional intervention designed to support practitioners to improve their practice, and that which they provide to service uses, which began in New Zealand in the 1980s. A mixed method descriptive research study design was used to determine what the current scope of this provision was, with the potential to develop a standardised tool in New Zealand (McKenna et al., 2010). The survey involved management level staff at both DHB’s and Non-Government Organisations (NGO’s) around New Zealand with the results showing that of the services able to provide accurate documentation on compliancy rates on the use of supervision, on average 75% of nurses were attending supervision (McKenna et al., 2010). The authors concluded that of the directors/managers surveyed, two thirds agreed that a ‘nationally agreed approach’ would be beneficial for professional supervision and the training of supervisors, however this would require the collaboration of DHB’s and NGO’s.

Clinical supervision is carried out in a formal manner and information discussed is confidential, unless of course there is a safety or ethical issue which would require further investigation. (McKenna et al., 2010). Ideally clinical supervision is available to all those working in the mental health, addiction and disability workforce, however at the time of McKenna et al’s (2010) study only 75% of nurses were utilising supervision.

Beneficial support

The most beneficial support that participants identified was that of collegial support at 71% (n=41), immediate and on-going. The participants in Bohan and Doyle’s (2008) study identified peer support as playing a vital role following a patient suicide or attempt, provided in a casual rather than a formal manner. Little (1992. P. 164) states the literature reports that “informal peer support was found to be extremely valuable”. Spencer’s (2007, p. 30) study reiterates this theme stating that “The participants favoured individual support and space rather than formal debriefing”. Linke et al. (2002) also documented that support from immediate colleagues was the most common source of support, as did Loos et al. (2014) who indicated that informal
debriefing with peers was a far more popular choice of support after a patient death than formal debriefing. The next support that was considered was leadership support however only 8 respondents (14%) reported this.

Least helpful support

The least helpful support after a patient suicide identified by participants was that of a ‘debrief session’ at 21% (n=12), which was felt to involve too many people, especially those not directly involved in the incident. Many of the respondents found debriefing to be a negative experience that was often incorrectly timed along with the feeling that an underlying ‘culture of blame’ existed. The general consensus of participants from Dearden’s (2004) study was that debriefing was of little use and potentially added more stress to a situation. Valente (2003) discusses the use of debriefing after a patient suicide as a common intervention, however states that according to the research literature its effectiveness is contradictory. Spencer (2007) discusses debriefing as an intervention to support someone in distress to help with the immediate pain of an event and to assist in preventing the development of difficulties in the future. Initially the term described a specific and defined intervention with a set approach to what was involved and could be used in an individual or group basis (Spencer, 2007). The original definition of debriefing originated more than 20 years ago and today the term is more widely used for a variety of interventions, making it difficult to prove its benefits due to a lack of a clear definition (Spencer, 2007). Loos et al. (2014) acknowledged the merits of formal debriefing in the theoretical literature however the practical, cultural and logistical issues in implementing it have the potential to hinder its use. Responses showed that 8 participants (14%) replied with “N/A / unsure / none” for this question, and 7 (12%) reported that managerial support was also seen as not being helpful due to the suggestion that their main focus was on protecting the organisation, along with concerns around risk of litigation.

Useful support

What 21% of the participants (n=12) thought would be useful after a patient suicide was what the individual nurse needed in terms of their own personal grieving. Whether this was talking with peers, time off to process the situation or attend the funeral, seek counselling or just acknowledgement that staff go through a grief process, while also giving consideration to the fact that the nurse may potentially be vulnerable. Participants from Dearden’s (2004) study reiterate this point with their suggestion of flexible support to meet the need of individuals. Other suggestions from these participants included an identified senior team member to ensure
the provision of support when needed, and a future follow up date to monitor for potential adverse effects (Dearden, 2004). Valente & Saunders (2002) suggest that gaining knowledge of bereavement and accessing support can help prevent negative effects such as stress and burnout. Loos et. al. (2014) suggests that a nurse’s grief must be recognised, acknowledged, accepted and appropriate support and education implemented to prevent adverse effects compounding and resulting in unresolved grief. A few participants from this study, 14% (n=8) believed that an appropriate timed debrief would be useful and 12% (n=7) reported “nothing additional”.

Comments

Free text comments consisted of suggestions such as increasing one’s self-awareness, the concept of understanding the situation and the impact this can have on nurses, along with the idea that individuals deal with situations in different ways. Participants also offered the insight for others to consider that despite repeated exposure to patient suicide all suicide victims are individuals, as are the circumstances surrounding their deaths.

The purpose of using the IES-R scale in the survey was to utilise an existing proven measurement tool that could evaluate any impact on nurses due to a patient suicide, providing quantitative data as evidence. The IES-R is an 88-point scale (22 questions with a ‘0 – 4’ rating scale) that can measure the severity of PTSD symptoms, which directly correlate to the diagnostic criteria documented in the DSM-IV. Asukai, Kato, Kawamura, Kim, Yamamoto, Kishimoto, Miyake & Nishizono-Maher (as cited in Takahashi et al., 2011) reported those scoring 25 or higher on this scale were in a group at high risk of experiencing PTSD based on screening results from their studies. Takahashi et al. (2011) reported 40 individuals within their study that were in this high-risk group out of 292 nurses who had experienced a patient suicide. It is therefore of paramount importance to note that 22 out of 58 respondents (38%) who participated in this survey scored more than 25 on the IES-R, potentially putting them in a group of high-risk individuals for experiencing PTSD symptoms. This information was gained by the author manually adding up the IES-R score for each individual participant then totalling how many scored more than 25 on the scale.

The three subscales that make up the IES-R scale are; intrusion, avoidance and hyperarousal; criteria B, C & D respectively in the DSM-IV. Of the three above mentioned subscales, apart from one question in particular from the avoidance subscale, the majority of answers given by the study participants correlated to the intrusion subscale, defined below:
B. The traumatic event is persistently reexperienced in one (or more) of the following ways:

(1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.

(2) recurrent distressing dreams of the event. Note: In children, there may be frightening dreams without recognizable content.

(3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience; illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). Note: In young children, trauma-specific reenactment may occur.

(4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

(5) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event


The correlation between the above intrusion subscale definition and the scoring of over 25 points on the IES-R scale indicates potential PTSD symptomology in 38% (N=22) of the participants who completed this study.

Other considerations

Other considerations that arose from the literature are mentioned in this section to highlight the many varied ways suicide can impact on health professionals. Participants from Bohan and Doyle’s (2008) study described feeling anxious, frightened and panicked after a patient suicide with the suggestion that an important factor in dealing with the panic is experience of the situation. Another consideration from the participants in this study was a feeling of helplessness when trying to comfort colleagues and patients when they themselves were traumatised (Bohan & Doyle, 2008). Cooper (1995a) also touches on the fact that mental health nurses working in inpatient settings may find themselves in the difficult position of dealing with traumatised patients after a suicide, when they have not yet had an opportunity to process the event. Bowers et al. (2006) stated that the ‘inexorable pace of ward life’ hindered staff from dealing with their feelings because of the need to continue caring for others on the ward as having staff meetings, cancelling patient leave and closing the ward were just not possible.
Gaffney et al. (2009) describe front line staff potentially struggling to come to terms with the suicide because of the need to deal with organisational and legal processes and others who are bereaved, while working and continuing to provide a professional service. Bohan and Doyle (2008) concluded that emotional reactions can be heightened following a patient suicide due to the difficulty of predicting the event itself. According to Cooper (1995a) suicide survivors can find themselves experiencing intense emotional reactions for which psychiatric staff would generally experience a ‘typical human reaction to trauma’ however because they occur in a psychiatric setting they have a ‘heightened significance’.

Midence et al. (1996) discuss the inevitability of suicide in psychiatric units and conclude that professional and emotional support is needed for nurses from their colleagues, senior nurses, psychiatrists and managers post a suicide. The authors also emphasized the importance of regular reviews of assessment and prevention policies (Midence et al., 1996). Cooper (1995a) also talks of the inevitability of suicide in a psychiatric inpatient setting and often the unpredictability of the event as documented in the literature. Of note, as raised by Gaffney et al. (2009, p. 652), unrealistic expectations that mental health professionals can predict and prevent suicide could also cause undue distress and they suggest fostering “a culture of openness in which suicide is anticipated as a possible outcome even with excellent standards of care.”

Joyce and Wallbridge’s (2003) study participants showed considerable diversity in how they were affected by a patient suicide making any standardised management protocol extremely difficult in relation to work related stress. Despite many participants being in favour of post incident debriefing, there were also those who were not, and no consensus was reached on who should attend and whether or not attendance should be mandatory (Joyce & Wallbridge, 2003). The authors concluded however that programs within the health institute available to staff members in the event of a critical incident (providing short term, urgent debriefing and counselling) continue to be appropriate in the workplace (Joyce & Wallbridge, 2003).

Gaffney et al. (2009) report the overall impression from its participants shows that each suicide is unique and therefore how each health professional is affected will differ. By implication, this will produce a variability in the type and level of support / intervention that is required by individuals (Gaffney et al., 2009). The authors suggest anticipating suicide due to the difficulty in predicting and at times preventing it, be prepared for it by planning in advance and finally by respecting individual differences (staff will bring their own personal experience and perceptions
Gaffney et al. (2009) details a clear desire from their participants for more information and specific training as well as professional guidelines, Midence et al. (1996) cites an overwhelming need for group and individual counselling and more knowledge, Bohan and Doyle’s (2008) participants also believed there was a need for on-going education about suicide and how to respond to it. 30 respondents from Linke’s (2002) study believed special meetings in the future could be helpful when discussing a suicide, 31 felt based on their initial professional training they felt inadequately prepared to deal with a suicide and thought further education would be useful based on the premise that suicides are likely to happen. Another concern was that of on-going or lasting effects caused by a patient suicide and the idea of follow up (Robertson et al., 2010), where Spencer (2007) suggested follow up 3 to 4 weeks post incident (to prevent stress and burnout), and Bohan and Doyle (2008) considered follow up could occur 3 or 6 months after the event.

Chapter summary

This chapter provides a discussion on the findings of this study and what nurses seek in terms of support, including a brief mention of gender differences. The three themes of support offered; collegial, debriefing and other are considered with findings providing participants thoughts on what was most beneficial, least helpful and useful after a patient suicide with a summary of some comments made. This chapter also examines the use of the IES-R in relation to determining symptoms of PTSD, which can assist in detecting if experiencing a patient suicide has an impact on mental health nurses in the long term. The discussion chapter concludes with suggestions of other considerations that have arisen from this study and could have a potential impact for future research.
Chapter Six: Conclusion, Limitations and Recommendations

Suicide is a global phenomenon and affects millions of lives every year with the potential to affect many more if suicide rates continue to increase. The impact of suicide is not only confined to family and friends, but impacts the lives of health professionals, particularly mental health nurses. How mental health nurses deal with the aftermath of patient suicide is dependent on their own personal experiences of death and the support they receive after the event from the work environment.

The objectives of this study were;

- To determine if there is an impact on mental health nurses when a patient dies by suicide
- To determine what support was offered at the time of the event, what support was most beneficial, what was least helpful and what could be useful in this situation
- To gain any further knowledge from nurses who have experienced a patient suicide to help educate and empower others.

A quantitative descriptive study with a purposive sample of mental health nurses was conducted to enable this research. To measure the impact of the most distressing patient suicide a mental health nurse had experienced while working in New Zealand, the IES-R was incorporated into the anonymous questionnaire to provide quantitative data for comparison with PTSD symptomology. The three subscales that correlate to the criteria for PTSD (as defined in the DSM-IV) are; avoidance, intrusion, and hyperarousal. Aside from one statement in the avoidance subscale, there was a strong correlation between the participant’s responses and the intrusion subscale showing that a patient suicide does impact negatively on mental health nurses. Along with this, it is of relevance to note that 22 of the 58 participants (38%) in this study scored higher than 25 on the IES-R scale (scale ranges from 0 – 88) indicating that those 22 nurses are in a group that are at high risk of developing PTSD from their experience of patient suicide.

Space was provided for free text answers for participants to describe what support they had been offered after the patient suicide, what they found beneficial, what was not, and would be helpful. The inclusion of the free text answers allowed the use of thematic analysis to produce three common themes, being; collegial support (peer and management/leadership support), debriefing (informal and formal) and ‘other’ (EAP and Clinical Supervision). From these findings collegial support was the most offered method of support, peer support was seen to be
the most beneficial, a debrief session was considered the least helpful (predominantly due to
timing), and ‘what the nurse needs’ as the most useful method of support.

Some participants believed that any support was better than nothing; there were those who
thought it should be talked about openly and those who thought it was better to deal with things
individually. Irrespective of these thoughts, the general consensus of the participants involved in
this study felt that peer support, especially from those who had been involved in the incident or
those who had had previous experience of a patient suicide, was deemed to be the best form of
support at this distressing time.

Findings from this study indicate that a patient suicide does have an emotional impact on mental
health nurses that is consistent with the limited literature available on this subject.

Limitations

Nurses and their experiences of the death of a patient is not a new phenomenon, the wealth of
research around oncology nurses experiences is an example, evidenced by the literature. A
patient who dies suddenly or who is expected to die does not make that choice to do so, as do
people who take their own lives. The potential impact on nurse’s experiences and practices
differs depending on the individual circumstances; however their experience of grief and loss
may well be similar.

This study is not generalisable due to its small sample size and was conducted in only one DHB.
The questionnaire for this survey was distributed via email, which is how service managers of
the mental health services communicate with their staff on a regular basis within the DHB.
However there are nurses that are computer illiterate and potentially missed the opportunity to
complete this survey. The distribution of this survey was dependent upon managers of mental
health services forwarding the original link and the reminder to mental health nurses working
within their area.

The differences between this research and others reviewed in the literature is the methodology
and variations in data collection tools used to determine an impact on mental health nurses and
other health professionals after a patient suicide. Participants answered questions around their
feelings and emotions related to a distressing event retrospectively, where the time elapsed since
the event could potentially impact on the severity of the symptoms.
The majority of the literature reviewed was conducted in an inpatient setting however this study surveyed nurses working in both inpatient and community settings. It has been documented that online surveys tend to have poor response rates, particularly when compared to paper surveys. In a world that has embraced technology, the occurrence of online surveys continues to increase and exhaust potential participants, particularly nurses, who have ever-increasing workloads on a daily basis. The researcher believes this could have potentially impacted on this research with a response rate of only 14%.

**Recommendations for clinical practice and future research**

Findings from this research indicate an on-going need for education and research around suicide and the impact this has on mental health nurses. The availability of clinical supervision and the importance of appropriately timed debriefing are two aspects that could enhance how patient suicide is experienced and supported in the future.

Future research around this topic could examine the impact of patient suicide on mental health nurses comparing male and female experiences with the potential for gender differences, as well the possible correlation of years worked as a registered nurse and number of patient suicides experienced. Another consideration for future research is the potential impact that post suicide investigations, such as coronial proceedings, has on mental health nurses as many respondents from this research described this as a negative and difficult experience.

Despite the low numbers of participants in this research, the importance of issues such as mental health nurses potentially developing PTSD after experiencing a patient suicide warrants further consideration in relation to on-going research in this area. Unresolved grief from experiencing patient suicide is one avenue that has the potential to be researched further however the terminology may vary according to perspective such as, ‘the emotional labour of nursing’ or ‘vicarious trauma’.

Finally, educational support in relation to dealing with suicide needs to be considered for nurses. It is the author’s belief that education on death and dying should be a compulsory part of undergraduate nurse training programmes and that further education is provided within individual work environments. Again, this presents another possible opportunity for further research that could support mental health nurses when dealing with patient suicide.
References


APPENDIX I

Impact of Event Scale – Revised (IES-R)
The Impact of Event Scale - Revised

**Instructions:** Below is a list of feelings that people sometimes experience after stressful life events. Please read each item, and then rate your own experience (at the time of the event) in regard to the most distressing patient suicide you have experienced in your career.

<table>
<thead>
<tr>
<th>Feeling</th>
<th>Not at all</th>
<th>A little bit</th>
<th>Moderately</th>
<th>Quite a bit</th>
<th>Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any reminder brought back feelings about it</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I had trouble staying asleep</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Other things kept making me think about it</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I felt irritable and angry</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I avoided letting myself get upset when I thought about it or was reminded of it</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I thought about it when I didn’t mean to</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I felt as if it hadn’t happened or wasn’t real</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I stayed away from reminders about it</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Pictures about it popped into my mind</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I was jumpy and easily startled</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I tried not to think about it</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I was aware that I still had a lot of feelings about it, but I didn’t deal with them</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>My feelings about it were kind of numb</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I found myself acting or feeling as though I was back at that time</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I had trouble falling asleep</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I had waves of strong feelings</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td></td>
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<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>about it</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I tried to remove it from my memory</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I had trouble concentrating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Reminders of it caused me to have physical reactions, such as sweating, trouble breathing, nausea, or a pounding heart</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I had dreams about it</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I felt watchful or on-guard</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I tried not to talk about it</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
APPENDIX II

EIT Research Ethics & Approvals Committee
Reference Number 36/14

30 June 2014

Kerry Cross
Masterate Nursing Student
C/- School of Nursing
EIT

Dear Kerry

I am pleased to inform you that your research project "The impact of patient suicide on mental health nurses" was approved by the Research Ethics & Approvals Committee at their meeting held on 27 June 2014.

You are reminded that should the proposal change in any significant way, then you must inform the Committee. Please quote the above reference number on all correspondence to the Committee.

The Committee wishes you well for the project.

Yours sincerely

Jeanette Fifield
Secretary – Research Ethics & Approvals Committee

Dr. Elaine Papps, Toni Woods