Caring for Suicidal Person: Engagement or Observation

[ABSTRACT]

Suicide is considered one of the most significant recent public-health problems facing several states of the world. Literature reported two key debated positions regarding the nursing care of suicidal person. These positions are outlined as the ‘observations’ position and ‘engagement’ position. This paper aims to discuss this debate in depth. Although the use of close observation seems to be the modus operandi for ‘care’ of the suicidal client currently, there are inadequate literatures that encourage the use of such approach for suicidal client. Linked to these concerns, there is an argument within the psychiatric nursing mostly that the practices of ‘close observation’ need to be evaluated and more therapeutic approach be used in its place. The author of this paper support the literatures that call for ‘engagement’ as a therapeutic approach instead of ‘close observation’ as merely supervision’. Engagement is involved in inspiring hope by means of therapeutic relationship. Moreover, it is involved in investigating and understanding the character of the clients’ problems that guided them to feel suicidal rather than just treating them mechanically as epitomized by close observations. Accordingly, the author advocates that a new approach of nursing engagement should replace close observation.

Keywords: Suicide, engagement, observation, psychiatric nursing.

INTRODUCTION

Suicide is considered one of the most significant recent public-health problems facing several states of the world (Cutcliffe & Stevenson, 2008a; Mehlum & Ramberg, 2010). According to the World Health Organization (WHO) statistics (2011) about one million people pass away from suicide every year; a "global" mortality rate of 16 per 100,000, or one death every 40 seconds. Moreover, in the previous 45 years suicide rates have raised by 60% globally. The epidemiological data additionally illustrated that specific sub-groups of the people have a predominantly high risk of suicide; and in addition pointed out that individuals with mental illnesses remain to be a mostly high risk group (Cutcliffe, Stevenson, Jackson, & Smith, 2006). Therefore, suicidal behaviors are robustly connected with the presence of mental disorders (Fortinash & Worrest, 2012). Psychiatric nurses play a major role in handling suicidal behaviors (Cutcliffe & Links, 2008; Sun, Long, Boore, & Tsao, 2005; Talseth & Gilje, 2011). This incorporates intervening in suicide attempts in addition to providing appropriate care to decrease the incidence rate of suicide (Chan,
Chien, & Tso, 2008). The specialty of psychiatric nursing has been characterized as a ‘broad church’ – a specialty that includes a number of contested areas and matters of contradictory opinions (Cutcliffe & Barker, 2002). One such debated issue is that of the suitable nursing care for the people who are at high risk of committing suicide (Cutcliffe & Ward, 2006). Literature reported two key positions regarding the nursing care of suicidal person (Bowles, Dodds, Hackney, Sunderland, & Thomas, 2002; Ray, Perkins, & Meijer, 2011). These positions are outlined as the ‘observation’ position and ‘engagement’ position, this paper aims to discuss this debate in depth. First, the paper describes the ‘observation’ as ineffective and defense nursing practice. Next, the author argues that ‘engagement’ is more effective and therapeutic for nurses to deal with suicidal persons. Lastly, the author provides a closure for the discussed ideas.

**Observation Versus Engagement**

Observation has been regarded as an essential part of the psychiatric nurse’s role in mental health practice (Peplau, 1952). Psychiatric nurses, usually observe the clients for particular signs and symptoms associated with suicidal and/or for self-harm of other types, for violent and aggressive behaviors toward others, for depressive behaviors, for psychotic manifestations, for substance misuse, for elopement, and for other behaviors (Bowers, Gournay, & Duffy, 2000). Standing Nursing and Midwifery Advisory Committee (2003) defined four levels of observation: level I – general observation; level II – intermittent observations; level III – within eyesight; level IV – within arm's length. The existing standard of care for suicidal patients in inpatient psychiatric settings is to observe those patients at all times by nurses at higher levels of observations (level III and level IV ) (Cox, Hayter, & Ruane, 2010; Kettles & Addo, 2009; Ray, et al., 2011). These higher levels of observation are usually called as ‘close observation’ (Bowers & Park, 2001; Jones & Jackson, 2004). Although the use of close observation seems to be the modus operandi for ‘care’ of the suicidal client currently, there are inadequate literatures that encourage the use of such approach for suicidal client (Cutcliffe & Stevenson, 2008a). Actually, perhaps the most significant limitation of the existing literature is that few studies have yet attempted to investigate if ‘being under’ particular levels of observation truly decreases the number of suicide trials, degree of suicidal ideation, or the client’s suicide risk (Cutcliffe & Stevenson, 2008b). Likewise, there are few studies that have tried to compare psychiatric care settings that use close observation against settings without close observation (Cutcliffe & Stevenson, 2008a; 2008b). Several studies have specified and have constantly revealed how ‘being under’ close observation is perceived as non-therapeutic (Bowles et al., 2002; Cutcliffe & Barker, 2002; Dodds & Bowles, 2001; O’Brien & Cole, 2003). These literatures indicate that non-therapeutic sides of close observation encompass: lack of privacy, violation of personal space, lack of recognition, lack of empathy, lack of information, disinterested practitioners, and confinement. Remarkably, a number of these studies have mentioned some therapeutic sides to close observations, too (Dodds & Bowles, 2001; O’Brien & Cole, 2003). The therapeutic sides have included: acknowledgement, observer intentions optimism, emotional support, protection, and distraction. However, there is a considerable body of literature that report even when close observations have some therapeutic usefulness for suicidal people, it is the particular practices and attitudes of the psychiatric nurse during the observations that experienced as therapeutic, and not the observation per se (Cutcliffe et al., 2006; Cutcliffe & Stevenson, 2007; Sun et al., 2005; 2006). Linked to these concerns, there is an argument within the psychiatric nursing mostly that the practices of ‘close observation’ need to be evaluated and more therapeutic approach be used in its place (Cox, et al., 2010). The author of this paper support the literatures that call for ‘engagement’ as a therapeutic approach instead of ‘close observation’ as merely supervision (Bowles et al., 2002; Vrale & Steen, 2005; Cox, et al., 2010). In contrast to observation, engagement is not needed highly qualified nurses and is not essentially ‘therapy’, it is merely what some nurse would make out as caring, empathizing or simply ‘being with’ instead of ‘looking on’(Bowles et al., 2002). Moreover, while close observation provides little in the way of relieving the suicidal person’s ‘psychache’, engagement often address the emotional, psychological and spiritual needs of those clients (Cutcliffe & Stevenson, 2008a). Literatures (Cutcliffe, 2002; Cutcliffe & Barker, 2002) clarify that ‘engagement’ includes three essential components: establishing a therapeutic relationship, communicating tolerance and acceptance, as well as hearing and understanding. Engaging with suicidal persons is obviously involved in forming a therapeutic relationship, since any further interpersonal
interventions provided to those clients to help concentrate on their suicidal feelings will necessitate to be based on a relationship (Cutcliffe & Barker, 2002). This therapeutic relationship not only provides the ground for additional interventions, but also is an influential intervention by itself (Peplau, 1988). Moreover, Collins and Cutcliffe (2003) emphasize that the majority of suicidal patients are looking for a therapeutic relationship that convey them hope and overturn the course towards death. This situation requires that efforts have to be made to inspire hope by engagement, instead of confirming despair by non-intervention or ‘close observation’ (Reeves, Bowl, Wheeler, & Guthrie, 2004). Regarding the second component of engagement, caring practice for the suicidal patient is involved in displaying tolerance and unconditional acceptance, that removes any feeling of coercion and psychological pressure (Cutcliffe & Barker, 2002). Importantly, the presence alone of these characters in the nurse would not be adequate; these characters also have to be communicated or demonstrated, and need to be genuine (Cutcliffe & Stevenson, 2007). In relation to the third component of engagement, Stuart (2001) indicates that using of hearing and understanding encourages the suicidal client to examine his/her thoughts and feelings, and offering the chance for the client to communicate painful emotions in a non-judgmental atmosphere. The weaknesses (or criticisms) of the ‘engagement’ position seem to be focused on the subsequent points. Firstly, it is a laissez-faire method, that would consequence in less alertness on the part of psychiatric nursing staff and would eventually lead to more patients committing suicide (Bowers, 2001). However, there are few literatures that supports Bowers’ point of view (Cutcliffe & Barker, 2002). Furthermore, in one such published empirical study on substituting observations with the engagement method (Bowles & Dodds, 2001) no such tragedy as Bowers expected happened and, in contrast, there were many analogous improvements. Secondly, engagement approaches are nothing more than a re-wording of close observations (Cutcliffe & Barker, 2002). Buchanan-Barker and Barker (2005) argued that there is a kind of disparity between ‘engaging’ and ‘observing’ jointly linguistically and in practice. In terms of linguistics, if we desire to value and highlight the sorts of activities connected with engagement (as a new notion of practice), logic would necessitate that we start by not naming it observation (Buchanan-Barker & Barker, 2005). In terms of practice, observation is only a small aspect of engagement, not vice versa. It is obvious that nurses cannot fail to observe if they are effectively engaged with the suicidal person (Barker & Cutcliffe, 2000). Conversely, several studies indicate that nurses can carry out observations without any kind of human engagement (Cutcliffe et al., 2006; Cutcliffe & Stevenson, 2008b; O’Brien & Cole, 2003).

CONCLUSION
Suicide symbolizes a growing problem, mainly for the psychiatric nurse. The two major current approaches of nursing care for the suicidal client can be classified as ‘close observation’ and ‘engagement’. There are resemblances between these approaches given that both are concerned with preserving the client’s safety. Nevertheless, there are critical differences that are acknowledged in the literature (Bowles et al., 2002). Engagement is involved in inspiring hope by means of therapeutic relationship. Moreover, it is involved in investigating and understanding the character of the clients’ problems that guided them to feel suicidal rather than just treating them mechanically as epitomized by close observations. There are a number of weaknesses have been attached to the engagement approach (e.g. It’s a laissez-faire and analogous to observation). On the other hand, when one thinks about the benefits of engagement as supported by the emergent literature (as discussed) and the weakness of the current close observation approach, in that case the need to replace observation with engagement becomes obvious. Accordingly, the author advocates that a new approach of nursing engagement should replace close observation.

Conflicts of interest
There is no conflict of interest has been declared by the author.

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REFERENCES


