Suicide prevention: a study of patients’ views

JOHN M. EAGLES, DAWN P. CARSON, ANNABEL BEGG and SIMON A. NAJI

Background Suicide prevention strategies are usually formulated without seeking the views of people with psychiatric illnesses.

Aims To establish what helped patients with severe psychiatric illness when they felt suicidal.

Method A semi-structured interview was constructed following transcribed interviews with 12 patients. This was administered to 59 out-patients with serious and enduring mental illness, focusing on factors they found helpful or unhelpful when at their most despairing.

Results Three-quarters of patients were in contact with psychiatric services when feeling at their lowest, and this contact was generally deemed to be helpful. Social networks were considered just as helpful as psychiatric services by the half of patients who discussed their feelings with friends or relatives. Religious beliefs and affiliations were helpful. Negative influences included the media and the stigma of psychiatric illness.

Conclusions Efforts at suicide prevention might usefully focus on enhancing patients’ social networks, increasing the likelihood of early contact with psychiatric services and decreasing the stigma attached to psychiatric illness. Larger studies of patients exposed to different service models would be informative.

Declaration of interest None.

Research into suicide is often predicated on the expectation that the findings may be helpfully applied to suicide prevention, even though this expectation can be viewed as optimistic for much research into the subject (Geddes, 1999; Mortensen, 1999; Eagles et al., 2001). In recent years the psychological autopsy method has been used increasingly, despite its methodological problems (Hawton et al., 1998). Notably, deficiencies of this method include the acquisition of a retrospective account from a third party, and the impossibility of hearing directly which factors or interventions might have averted the suicide. For psychiatric services, our main opportunity of influencing suicidality is, perhaps self-evidently, with patients with mental illness. In an era when involvement of service users in policy-making and in research is increasingly advocated (Faulkner & Thomas, 2002), it is perhaps surprising that patients’ views on suicide prevention strategies have not hitherto been sought systematically. On the basis that most people who suffer from severe and enduring mental illness will at some point have contemplated or attempted suicide, we thought that it might be instructive to ask such patients about factors which they felt might have helped prevent them from contemplating suicide.

METHOD

Three of the authors (D.P.C., J.M.E., S.A.N.) considered and discussed the many factors that might protect from, or give rise to, suicidality among patients with severe and enduring mental illness. These factors formed a loose structure for detailed, free-ranging, tape-recorded interviews with 12 patients who were recruited from J.M.E.’s community mental health team case-load. These interviews were transcribed and the transcriptions were scrutinised with a view to the extraction of themes and the design of a semi-structured questionnaire. Thirteen consultant colleagues were then asked to give names of suitable patients for interview. From each team, we asked for up to ten patients with a clinical diagnosis of schizophrenia or schizoaffective disorder and for up to ten patients diagnosed with either bipolar or unipolar recurrent affective disorders. We requested that the patients selected should be as representative as possible of the consultant’s overall patient population, excluding patients only if it was felt that it might be counter-therapeutic to approach them. Participants who were currently receiving out-patient treatment were requested, but partly as a criterion of severity of illness, such participants should have had at least one previous psychiatric admission. The consultants from whom patients’ names were requested worked in teams based across Aberdeen and Aberdeenshire; patients were offered travel expenses to attend interviews. The researchers (D.P.C. and A.B.) contacted the patients directly, by letter and/or by telephone, explained the purpose of the interview and invited their participation. An average interview was 60–90 minutes in duration. Most interviews took place at the Royal Cornhill Hospital, Aberdeen; a few were held in general practitioners’ surgeries and a few in the patients’ homes. Approval to conduct the study was obtained from the Grampian Research Ethics Committee.

We anticipated that most of the patients would have at times felt very low and despairing, and that for many of them this would have given rise to suicidal feelings and/or actions. Patients were asked to identify the time during their illness when they felt at their most despairing, and most of the interview focused on this period with regard to factors that might have alleviated or precipitated suicidal feelings.

Of the 250 patients deemed potentially suitable by their consultant psychiatrists, letters inviting participation were sent to 242. Of these patients 164 responded, of whom 86 agreed to be interviewed. Appointments were agreed with 67 patients, of whom 59 attended and their interviews gave rise to useable data. Of these 59 patients, 27 were male and 32 were female. Their mean age at the time of interview was 47.4 years (s.d.=12.7 years). The mean duration of illness (from time of first presentation to services) was 16.2 years (s.d.=12.9 years). Diagnostically, 17 participants had schizophrenia or schizoaffective disorder, 18 had bipolar affective disorder and 24 had a recurrent depressive disorder.
Where appropriate, patients were asked to
What was helpful?

(69%) had deployed self-help strategies such
(37%) reported praying. Forty-one patients
with people in their social network such as
able to discuss their feelings and thoughts
when they were at their worst, they had been
helplines. Patients were asked whether,
ians and 2 (3%) contacted other telephone
common. Only 7 patients (12%) visited a
with other helping agencies was even less
patients (24%) were not in contact with

dom) were as follows: psychiatric services
dificant differences (all with 1 degree of free-
a bit worse, a lot worse). Statistically signif-
a bit) and ‘not helpful’ (no better/no worse,
atical comparisons, these relatively small
categories (all with 1 degree of freedom)
were as follows: psychiatric services were
deemed more helpful than general prac-
titioners (\(\chi^2=4.16, P=0.041\), odds
ratio (OR) 2.8; 95% CI 1.0–7.7) and more
helpful than other agencies (\(\chi^2=12.81,\nP<0.001, \text{OR } 7.91; 95\% \text{ CI } 2.4–26.5\)).
Patients’ social networks were also deemed
more helpful than other agencies (\(\chi^2=8.69,\nP=0.003, \text{OR } 6.1; 95\% \text{ CI } 1.8–21.4\)).

Fifteen patients (25%) said that their
religious beliefs prevented them from
attempting suicide. Praying was deemed to
have helped a great deal at this time by 4
patients and to have helped a bit by 10.
Of the 15 patients who consulted a minister
or priest while at their lowest, 3 derived a
great deal and 6 a bit of help. Self-help
strategies gave a great deal of help for 16
of the 59 patients (27%).

Patients were asked open-endedly what
they had considered to be the most helpful
factor when they were feeling at their
worst. Of the 56 who cited a most helpful
factor, this related to someone in their
social network for 23 and for 22 patients
it comprised some aspect of assistance from
psychiatric services.

What was unhelpful?

When patients were at their worst, 37
(63%) were in employment. For these 37
people, 4 perceived work as making no
difference to their well-being at this time,
6 thought working helped them, and 27
considered that it made them feel worse.

Patients were asked whether, when at
their lowest, items in the media had made
them feel even worse or suicidal. Items in
newspapers or magazines had done so for
18 patients (31%), items on television for
24 (41%) and on the radio for 7 (12%).
This was balanced by the 25 patients
(42%) who reported that something in the
media had been positively helpful.

A sizeable majority (83%) of patients
were conscious of the stigma associated
with mental illness when feeling at their
worst, and 35 (59%) felt that this stigma
had contributed to their feeling at their
worst. Twelve patients (20%) quantified
stigma as contributing ‘a great deal’ to their
feelings at this time.

With regard to substance misuse, only 8
patients (14%) had been using non-
prescribed drugs, and only 4 (7%) felt that
these drugs were a problem. With regard to
alcohol, 15 patients (25%) were exceeding
safe drinking levels, and 11 (19%) per-
ceived alcohol to have been a problem at
that time. Alcohol was perceived as helpful
to 17 patients (29%) when they were feeling
at their worst.

DISCUSSION

Main findings of study

Most patients had experienced suicidal feel-
ings and many had acted upon these.
Psychiatric services and patients’ social net-
works were deemed particularly helpful,
but when at their worst nearly a third of
participants were not yet in contact with
services and nearly half did not discuss their
feelings with people in their social net-
woks. Religion and self-help strategies
were also helpful, whereas employment,
stigma and the media were generally
unhelpful.

Methodological considerations

Our patients lived in the north-east of
Scotland, where there is low geographical
mobility, and would thus generally have

<table>
<thead>
<tr>
<th>Table I</th>
<th>Frequency and helpfulness of contact when patients (n=59) felt at their most despairing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact</td>
<td>Patients having contact</td>
</tr>
<tr>
<td></td>
<td>n (%)</td>
</tr>
<tr>
<td>General practitioner</td>
<td>37 (63)</td>
</tr>
<tr>
<td>Psychiatric services</td>
<td>45 (76)</td>
</tr>
<tr>
<td>Other helping agencies</td>
<td>19 (32)</td>
</tr>
<tr>
<td>Discussion within social network</td>
<td>32 (54)</td>
</tr>
</tbody>
</table>
noteworthy that participation was much more likely among patients with affective disorders than among those with schizophrenia or schizoaffective disorders. The difficulties of recruiting people with schizophrenia into research studies has been described previously – ‘people with predominantly positive symptoms were suspicious of our motives, while those with negative symptoms were unmotivated to take part’ (Lester & Wilson, 1999) – and this unfortunately led to an underrepresentation of their views in our study. Psychological autopsy studies, often because of lack of availability or cooperation of key informants, are also prone to be unrepresentative owing to selective recruitment (Appleby et al, 1999a; Cavanagh et al, 1999). Another shared difficulty with psychological autopsy studies is that ours was necessarily retrospective, but our information did derive directly from the patients themselves without the risk of distortion and of retrospective explanation inherent in the accounts of key informants.

**Helpful factors**

Reassuringly, psychiatric services were generally deemed to be helpful. Although the quarter of ‘suicide-surviving’ patients not in contact with psychiatric services gives rise for concern, it does contrast strikingly with the figures for completed suicide, which show that only a quarter of people committing suicide had contact with psychiatric services during the preceding year (Appleby et al, 1999b). Among our sample, nearly two-thirds of participants had been in contact with their general practitioner, and again this contrasts with lower rates of contact seen in cases of completed suicide (Matthews et al, 1994), especially among young people (Vassilas & Morgan, 1993). The higher rates of service contact among our ‘suicide survivors’ and the perceived helpfulness thereof argue strongly that measures directed at enhancing the likelihood of contact with services may be more likely to pay dividends in suicide prevention than measures directed at changing the services themselves, especially when more-intensive interventions do not appear to reduce suicidal behaviour among those with serious mental illness (Walsh et al, 2001). It is noteworthy that many of our patients had attempted suicide and it may be that their contacts with services rendered these attempts less likely to end in a completed suicide.

With regard to patients’ reported contacts with people in their social networks, there were two striking findings. Confiding in family and friends was deemed as helpful as contact with psychiatric services, but only 34% of patients took (or had the opportunity to do so. There is a vast literature on the relationship between suicide and social support/integration. In summary, social support protects against suicide, but mental illness may reduce the likelihood of experiencing such support (Heikkinen et al, 1993; Johansson et al, 1997; Whitley et al, 1999; Stack, 2000). There are clear implications for the desirability of enhancing supportive social networks among those with mental illness.

The helpfulness of the statutory and voluntary agencies was less apparent, and relatively few patients had contact with these agencies. This may in part reflect the growth of voluntary agencies over recent years which may post-date the period when some of our patients felt at their worst. The findings might also suggest that, notwithstanding the role of organisations such as the Samaritans for suicidal members of the general population, suicide prevention strategies for those with severe mental illness should be targeted in other directions.

Religious beliefs and activities were reported to be helpful. Epidemiologically, there is a fairly consistent negative association between a population’s religiosity and its suicide rate (Nisbet et al, 1997). People who commit suicide have been found to be less religious than population controls. In Northern Ireland, this relationship did not endure after controlling for the presence of psychiatric illness (Foster et al, 1999), but in the USA the protective effects were found to be independent of any increased social contact to which religious activities might give rise (Nisbet et al, 2000).

Self-help strategies were used by a considerable number of patients. This emphasises the need for a balance between active help and intervention on the one hand, and fostering patients’ autonomy and self-reliance on the other.

**Unhelpful factors**

Although the negative effects of stigma and the media might have been anticipated, the frequency with which these factors were identified as unhelpful was surprising, albeit based on retrospective judgements of events often occurring some years previously. Stigmatisation of people with mental illness is common (Crisp et al, 2000) and its aetiology is complex (Haghighat, 2001; Kendell, 2001). It is likely to be exacerbated by inaccurate representations of psychiatric illness in the media (Berlin & Malin, 1991), but guidelines and feedback can render media reporting more responsible (Michel et al, 2000). These factors, and the patients’ reports in our own study, underline the importance of the Royal College of Psychiatrists’ efforts to reduce stigma and improve media coverage of psychiatric illnesses.

Epidemiologically, a fairly consistent relationship emerges between suicide and unemployment (Lewis & Sloggett, 1998; Gunnell et al, 1999). However, in case-control studies some find a positive, independent association between suicide and unemployment (Foster et al, 1999; King et al, 2001) whereas others do not (Beautrais et al, 1998; Appleby et al, 1999a), raising the possibility that suicidal behaviour and unemployment might be linked through the presence of psychiatric illness. Our patients tended to experience work as a difficulty rather than as a help, suggesting that employment per se was not protective against suicidal ideation. That is not to say, of course, that unemployment would have had a less negative impact than did
the stresses of working while psychiatrically unwell.

**Implications and suggestions**

Surprisingly, it seems to be novel to see people with serious psychiatric illness as ‘suicide survivors’ and to seek their views to inform suicide prevention. Notwithstanding the likely problems in recruitment, a larger and representative cohort who have experienced a wider range of service provision and voluntary agencies should yield data which could be generalised with more confidence. Meanwhile, the findings from our preliminary study with regard to suicide prevention suggest that:

(a) efforts to increase the likelihood that people with psychiatric illness will get in contact with services are more likely to be helpful than changes to those services;

(b) attempts to enhance patients’ social networks should be intensified;

(c) patients’ religious affiliations should be fostered;

(d) attempts to reduce stigma and improve media coverage of psychiatric illness should continue.

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